ProActive Health PLLC

1. **Please enter your information.**

First Name: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Divorced ○ Other

Address: _____ Apt./Unit #: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

Occupation _____

2. **Location of pain (Once marked, specify which side the painful body part is located [left, right, etc.])**

☐ Head _____
☐ Neck _____
☐ Shoulder _____
☐ Elbow _____
☐ Wrist/Hand _____
☐ Chest _____
☐ Abdomen _____
☐ Upper back _____
☐ Mid back _____
☐ Lower back _____
☐ Hip _____
☐ Sacrum _____
☐ Knee _____
☐ Ankle/Foot _____

3. **How long have you had this pain?**

_____

4. What caused this pain to begin?

_____

5. How would you describe your pain? (Add location for each sensation if you have more than one location of pain)

- ☐ Dull/achy _____
- ☐ Sharp _____
- ☐ Numbness/tingling _____
- ☐ Burning _____
- ☐ Stabbing _____
- ☐ Intermittent _____
- ☐ Constant _____
- ☐ Deep _____
- ☐ Other _____

6. On a scale of 0-10 (0 is no pain, 10 is worst pain imaginable), choose the number that best describes your average pain?

- ○ 0
- ○ 8
- ○ 5
- ○ 2
- ○ 10
- ○ 7
- ○ 4
- ○ 1
- ○ 9
- ○ 6
- ○ 3

7. Any prior history with your current pain that may be contributing?

- ○ Yes
- ○ No

8. In general, is your pain improving or worsening?

- ○ Improving
- ○ Worsening
- ○ Stable