United Medical Clinics

Patient Chronic Pain Supplemental Form

Patient Information

First Name _____ Last Name _____ DOB _____

Phone # _____ EMAIL _____ Date _____

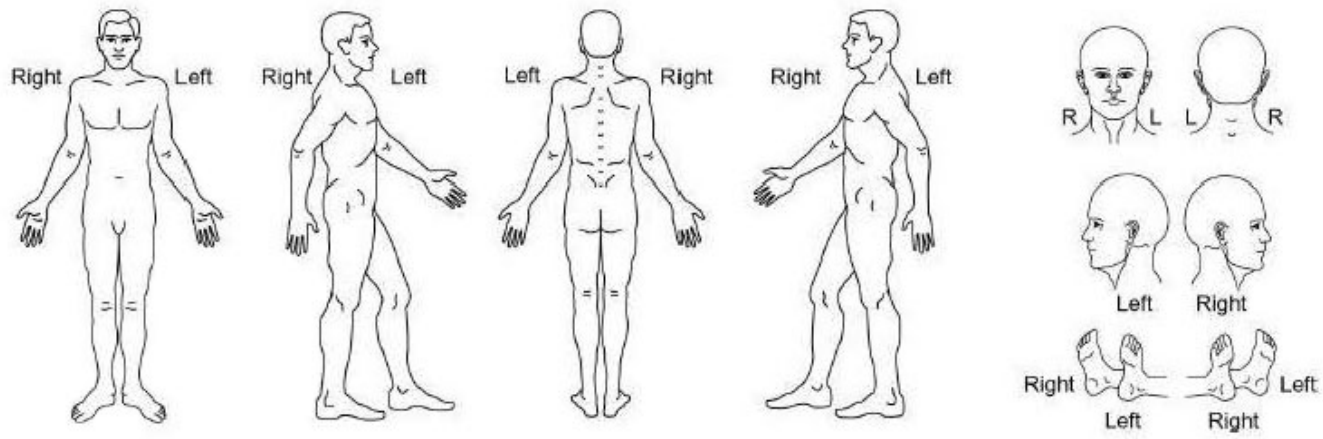
Chronic Pain History

Chief Complaint (where is your chronic pain the most extreme?) _____

Does this pain travel? _____ If so, where? _____

Please list any additional areas of pain _____

Use this diagram to indicate the area of your pain. Mark all locations with an "X"



Onset of Symptoms

Approximately when did this pain begin? _____

What caused your current pain episode?_____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your chronic pain began, how has it changed? ☐ Improved ☐ Worsened ☐ Same

Pain Description

When is your pain the worst? ☐ Mornings ☐ Daytime ☐ Evenings ☐ Middle of the night

☐ Always the same

Pain Description Continued

Check all of the following that describes your pain:

☐ Dull/Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp ☐ Cramping

☐ Numbness ☐ Spasming ☐ Throbbing ☐ Squeezing ☐ Tightness

☐ Tingling/Pins and Needles

How often does your pain occur? ☐ Constant ☐ Intermittent ☐ Always changing

If "0" is NO PAIN and "10" is the Worst Pain you can imagine, please rate your pain:

Right Now _____ The Best It Gets _____ The Worst It Gets _____

Mark the Pain Level

	Increases	Decreases	No Change
Bending Backward	☐	☐	☐
Bending Forward	☐	☐	☐
Changes in Weather	☐	☐	☐
Climbing Stairs	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Driving	☐	☐	☐
Lifting Objects	☐	☐	☐
Looking Downward	☐	☐	☐
Rising from seated Position	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐

Any other factors that contribute to your pain that is not listed above?

_____

_____

Associated Symptoms

Numbness/Tingling	☐ Yes	☐ No	Weakness in the arm/leg	☐ Yes	☐ No
Balance Problems	☐ Yes	☐ No	Bladder Incontinence	☐ Yes	☐ No
Joint Swelling	☐ Yes	☐ No	Fever Chills	☐ Yes	☐ No