



When did your symptoms begin:

Briefly describe your symptoms:

How did your symptoms start:

Average pain intensity:

Last 24 hour: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

How often do you experience your symptoms:

(1) Constantly (76%-100% of the time) (3) Occasionally (26%-50% of the time)

(2) Frequently (50%-75% of the time) (4) Intermittently (0%-25% of the time)

How much have your symptoms interfered with your usual daily activities:

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

How has your condition changed since care at this facility:

(0) N/A - This is the initial visit (1) Much worse (2) Worse (3) A little worse

(4) No change (5) A little better (6) Better (7) Much better

How would you say your overall health is right now:

(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

Current Medications:

Medical Conditions:

Patient Signature: X

Date: