ADDITIONAL CONCERNS

Today's Date: _____

Annapolis Pain Management
45 Old Solomons Island Rd. Ste 205
Annapolis, MD 21401
P: 410-224-4348 F: 410-224-4732

Patient Name_____ **DOB**_____

- *Complaint* #2: _____ **Location: L / R / Bilateral**

- When it started: ☐ **days** ☐ **weeks** ☐ **months** ☐ **years** **Date**_____

- **Severity of Discomfort: Current** ____/10 At it's **Best** ____/10 At it's **Worst** ____/10 **Average** ____/10

- Mechanism of injury (How it happened): _____

- Frequency: ☐ Constant ☐ Frequent ☐ Intermittent ☐ Off and On ☐ Random ☐ Recurring

- Quality: ☐ Aching ☐ Burning ☐ Tingling ☐ Numbing ☐ Sharp ☐ Other_____

- Radiating Pain: ☐ None To:_____

- Provoking factors:_____

- Modifying factors: Relieved by: _____

- Medications Tried: ☐ NSAID ☐ Steroid ☐ Muscle Relaxer ☐ Rx. Pain Med

- Previous Episodes: ☐ Yes ☐ No Details:_____

- Previous Care: ☐ Medical ☐ Physical Therapy ☐ Chiropractic ☐ Other:_____

- Recent Diagnostic Tests: ☐ YES ☐ NO Details:_____

- ADL/Functional Deficits most affected: ☐ Work ☐ Lifting ☐ Personal Care ☐ Sitting

☐ Standing ☐ Sleeping ☐ Bending ☐ Traveling ☐ Driving ☐ Walking

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***Complaint* #3:** _____ **Location: L / R / Bilateral**

- When it started: ☐ **days** ☐ **weeks** ☐ **months** ☐ **years** **Date**_____

- **Severity of Discomfort: Current** ____/10 At it's **Best** ____/10 At it's **Worst** ____/10 **Average** ____/10

- Mechanism of injury (How it happened): _____

- Frequency: ☐ Constant ☐ Frequent ☐ Intermittent ☐ Off and On ☐ Random ☐ Recurring

- Quality: ☐ Aching ☐ Burning ☐ Tingling ☐ Numbing ☐ Sharp ☐ Other_____

- Radiating Pain: ☐ None To:_____

- Provoking factors:_____

- Modifying factors: Relieved by: _____

- Medications Tried: ☐ NSAID ☐ Steroid ☐ Muscle Relaxer ☐ Rx. Pain Med

- Previous Episodes: ☐ Yes ☐ No Details:_____

- Previous Care: ☐ Medical ☐ Physical Therapy ☐ Chiropractic ☐ Other:_____

- Recent Diagnostic Tests: ☐ YES ☐ NO Details:_____

- ADL/Functional Deficits most affected: ☐ Work ☐ Lifting ☐ Personal Care ☐ Sitting

☐ Standing ☐ Sleeping ☐ Bending ☐ Traveling ☐ Driving ☐ Walking

Provider Signature:_____ Date:_____