Name:_____

Please circle what applies to you

Pain level **without** current medication: 1 2 3 4 5 6 7 8 9 10
Pain level **with** current medication: 1 2 3 4 5 6 7 8 9 10
Pain level today: 1 2 3 4 5 6 7 8 9 10

Pain is **currently located**: Head, Neck, Back, Shoulders, Arms, Hips, Legs, Feet, Joints, Everything

When did you take your pain medicine last?_____
If **NOT** today,
why?_____

Timing of your pain: Continuous OR Intermittent

Pain is described: Dull, Aching, Throbbing, Sharp, Burning, Numbness, Tingling, Stabbing, Weakness, Stiffness, Cramping, Hot, Cold, Pinching, Pressure, Shooting, Spasm, Squeezing, Stinging, Tenderness, Grinding

Pain is associated with: Decreased Function, Anger, Anxiety, Blurred Vision, Appetite change, Fatigue, Headache, Numbness, Poor sleep, Depression

Pain is aggravated by: Walking, Bending, Sitting, Work, Physical Therapy, Shopping/Yard work, Household chores, Weather changes, Cold, Lifting, Lying down, Movement, Sitting to Standing, Everything, Nothing

Pain is improved with: Bed-rest, Traction, Exercise, Massage, Medication, Physical Therapy, TENS Unit, Back Brace, Heat, Ice, Aquatic Therapy, Injections, Relaxation, Lying down, Nothing, OTC medication, Position change, Sitting, Standing, Walking, Stretching

Have you been to the hospital/ER since your last visit? Yes No

Please turn page over and complete the back side :)

What pharmacy would you like your medication(s) sent to?

Name _____ Town _____

Have you fallen since your last visit? Yes No

Have you had a Flu shot this season? Yes No

If yes, who was it given by? Primary Care Pharmacy

Have you had a pneumonia shot in the last 5 years? Yes No

If yes, who was it given by? Primary Care Pharmacy

Are you a current smoker? Yes No

Have you ever smoked? Yes No

Do you **currently** drink ANY alcohol? Yes No

Have you ever drank alcohol in the **past**? Yes No

Are you feeling down, depressed or hopeless? Yes No