Pain Management Associates, Inc.

Patient's Name:_____

Date of Birth:_____

I Have an Advanced Directive: ❑ Yes ❑ No

How long have you noticed your pain?
___ Days ___ Weeks ___ Months ___ Years

How often do you feel pain? (Check ONE)
❑ Constant ❑ Intermittent ❑ Occasional

What makes the pain worse? (Ex. Sitting, standing, etc.)

What relieves your pain? (Ex. Sitting, standing, etc.)

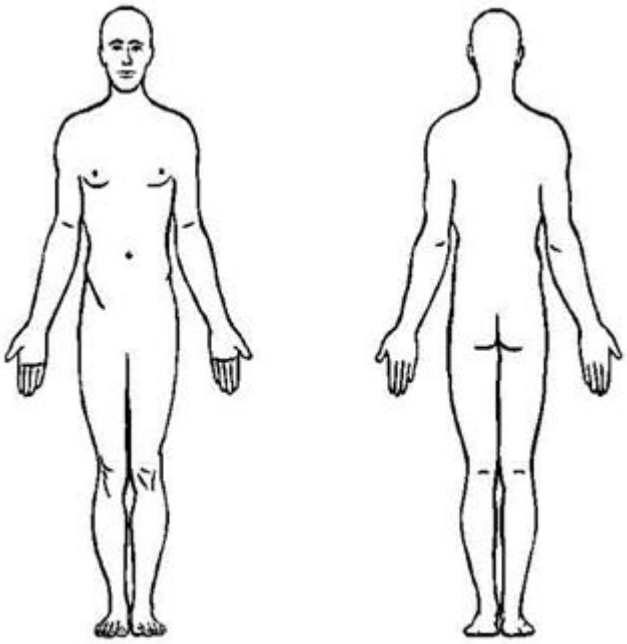
Was there any injury/event that caused the pain?
❑ No
❑ Yes, explain:

Have you had surgery on your back/neck?
❑ No
❑ Yes, explain:

Describe your pain (check all that apply):

❑ Burning	❑ Stabbing
❑ Sharp-shooting	❑ Deep-pressure
❑ Tingling	❑ Tightness
❑ Numbness	❑ Spasms
❑ Pinprick	❑ Other, explain:

Please draw the location of your pain:



Please list all your allergies including your reaction (hives, anaphylaxis, etc.):

1.
2.
3.
❑ **No known allergies**

Please list all your current medications including their dosages:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Patient Name: _____ Date: _____