PATIENT INFORMATION SHEET

Name: _____ Date: _____ Sex: M / F

Full Address:_____

Home Phone #: _____ Work Phone #: _____

Date of Birth: _____ Age: _____ Email: _____

***I consent to receive email correspondence from Dr. Macdonald □ Yes □ No**

Have you attended a seminar of Dr. Macdonald's? _____ Do you have extended health coverage? _____

Premium Assistance? Yes_____No_____ If Yes, Care Card # _____

How did you hear about us? _____

Medications: _____

Present Complaint: _____

_____

_____

Pain or problem started on _____

Pains are: Sharp ☐ Dull ☐ Constant ☐ Intermittent ☐

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with your work? ____ Sleep? ____ Daily Routine? ____ Other? _____

Is condition getting progressively worse? _____

Have you seen any other Doctors or therapists seen for this condition, what did you have done and did it help? _____

_____

Are you taking and medications for this condition? _____

Have you had any surgeries that relate to this condition?_____

Other Symptoms:

☐	Headaches	☐	Pins and Needles in legs	☐	Fainting
☐	Neck Pain	☐	Pins and Needles in Arms	☐	Loss of Smell
☐	Sleeping Problems	☐	Numbness in Fingers	☐	Loss of Taste
☐	Back Pain	☐	Numbness in Toes	☐	Diarrhea
☐	Nervousness	☐	Shortness of Breath	☐	Feet Cold
☐	Tension	☐	Fatigue	☐	Hands Cold
☐	Irritability	☐	Depression	☐	Stomach Upset
☐	Chest Pains	☐	Lights Bothers Eyes	☐	Constipation
☐	Dizziness	☐	Loss of Memory	☐	Cold Sweats
☐	Face Flushed	☐	Ears Ring	☐	Loss of Balance
☐	Neck Stiff	☐	Fever	☐	Buzzing in Ears

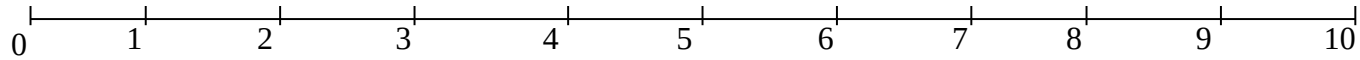
LA____ LR#_____ Area:_____

Patient Pain Assessment

Name: _____ _____ _____

Last **First** **Date**

0-10 Numeric Pain Intensity Scale (1)



No Pain **Mild Pain** **Moderate Pain** **Severe Pain** **Very Severe** **Intolerable Pain**

1) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 2 weeks.

0 1 2 3 4 5 6 7 8 9 10
No Pain Intolerable Pain

2) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 2 weeks.

0 1 2 3 4 5 6 7 8 9 10
No Pain Intolerable Pain

3) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0 1 2 3 4 5 6 7 8 9 10
No Pain Intolerable Pain

4) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0 1 2 3 4 5 6 7 8 9 10
No Pain Intolerable Pain

5) What medications and how many are you taking for your pain? _____

6) Circle the one number that describes how, during the past 2 weeks, pain has interfered with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

B. Walking ability

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

C. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

D. Sleep

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

E. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes