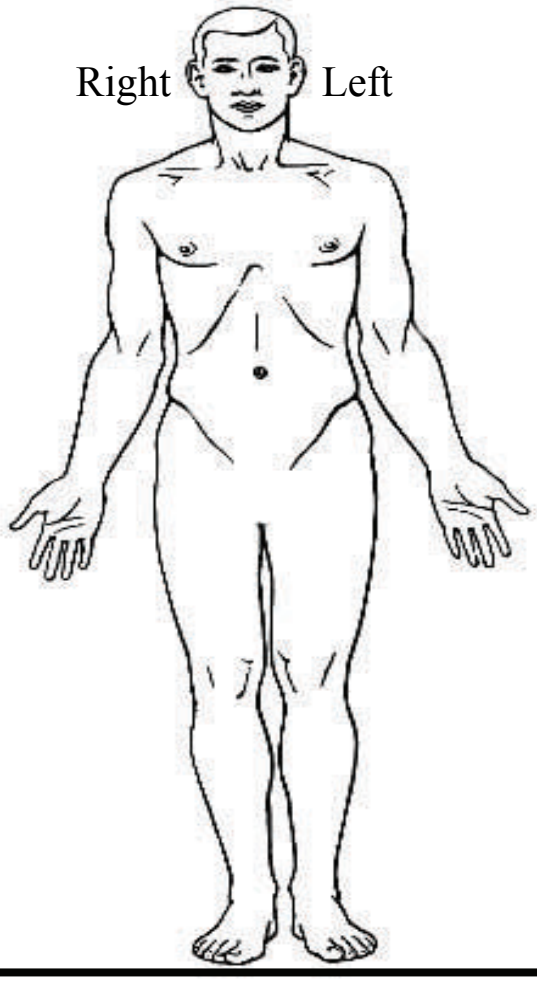
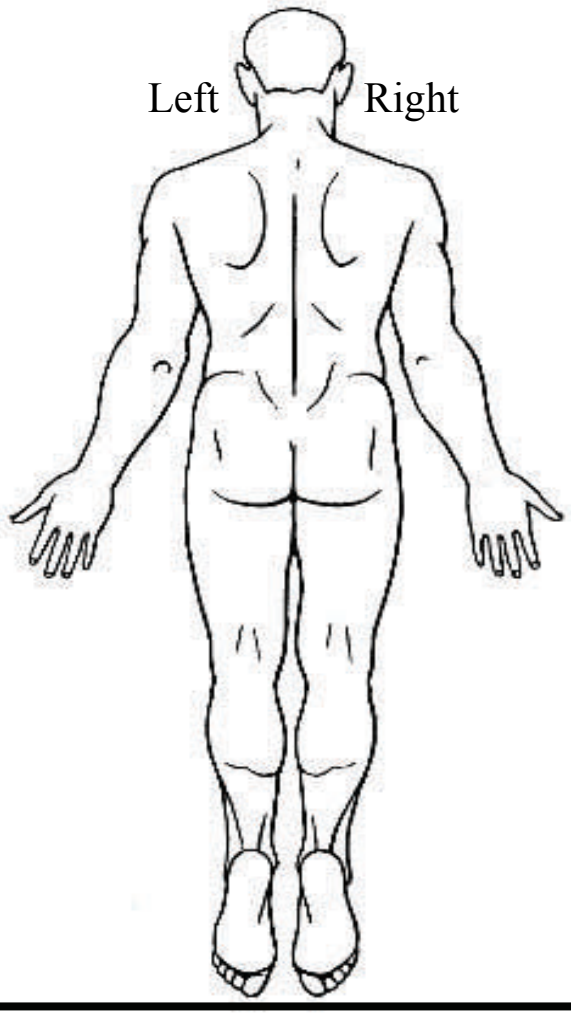
SPINE INSTITUTE *of Arizona*

Patient Name: _____

Date: _____

Please mark an "X" on the body part(s) where you have pain.
Mark a "0" on the body parts where you have numbness.





NECK

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Possible pain

BACK

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Possible pain

RIGHT ARM

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Possible pain

RIGHT LEG

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Possible pain

LEFT ARM

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Possible pain

LEFT LEG

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Possible pain

REVIEW OF SYMPTOMS

In the past month, have you experienced any of the following?
Please put a check mark in front of any/all of the following that you have experienced.
If you have experienced any of the symptoms, please be sure to notify your family doctor

H.E.E.N.T.

- ☐ Blurred vision
- ☐ Dry Eyes
- ☐ Hard of hearing
- ☐ Nasal Congestion
- ☐ Sore Throat
- ☐ Cough
- ☐ Other_____

INTEGUMENTARY

- ☐ Moles
- ☐ Skin Rash
- ☐ Other:_____

NEUROLOGIC

- ☐ Tremors
- ☐ Other:_____

GENERAL

- ☐ Fevers
- ☐ Chills
- ☐ Night Sweats
- ☐ Stress
- ☐ Poor sleep
- ☐ Swelling of feet
- ☐ Swollen glands
- ☐ Problems with blood clots
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Other_____

PULMONARY

- ☐ Shortness of breath
- ☐ Other_____

GASTROINTESTNAL

- ☐ Abdominal Pain
- ☐ Other

ABDOMINAL

- ☐ Abdominal Pain
- ☐ Other_____

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Other_____

WORK STATUS

☐ Full Time ☐ Regular Duty

☐ Other_____

☐ Restrictions: _____

SPINE INSTITUTE *of Arizona*

Patient Name: _____

Date: _____

This form must be filled out at each office visit.
We are required to have documentation of medications and allergies for each office visit; because of this we are unable to accept "no change" or "same as before" answers on this form.

Medications currently taking	**Dosage**	**Frequency**
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Allergies:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Pharmacy:

Name: _____

Address: _____

Phone: _____