



Patient Name: _____

Date _____

(208)344-4469

Primary condition that I am concerned with:

Location of Pain: _____

When it began: _____

How did it occur: _____

The pain is: Sharp Dull Burning
 Pressure Itching Pins & Needles
 Other: _____

% of time with pain: 0--10--20--30--40--50--60--70--80--90--100 or constant pain

Intensity of pain: 0 or no pain--1--2--3--4-- or severe pain

Does the discomfort radiate or extend from one point to another? Yes No

If yes, please describe: _____

Condition is aggravated by: _____

Relieved by: _____

Affect on daily activity: _____

Affect on sleep: _____

Progress: Getting worse Staying the same No change

Related to fall or accident: Yes No

Has this ever happened before: Yes No

Other Doctors seen for this condition: _____

What other things have you done to try to relieve this problem:

Over the counter medication Heat Stretching
 Prescription medication Ice Exercise
 Other: _____

Second condition that I am concerned with:

Location of Pain: _____

When it began: _____

How did it occur: _____

The pain is: Sharp Dull Burning
 Pressure Itching Pins & Needles
 Other: _____

% of time with pain: 0--10--20--30--40--50--60--70--80--90--100 or constant pain

Intensity of pain: 0 or no pain--1--2--3--4-- or severe pain

Does the discomfort radiate or extend from one point to another? Yes No

If yes, please describe: _____

Condition is aggravated by: _____

Relieved by: _____

Affect on daily activity: _____

Affect on sleep: _____

Progress: Getting worse Staying the same No change

Related to fall or accident: Yes No

Has this ever happened before: Yes No

Other Doctors seen for this condition: _____

What other things have you done to try to relieve this problem:

Over the counter medication Heat Stretching
 Prescription medication Ice Exercise
 Other: _____

If you have any other health concerns or need additional forms, please ask for another questionnaire.