PATIENT INFORMATION SHEET

Name:				_ Sex:	Sex: M / F	
Full Address:						
Home Phone #: Work Phone #:						
Date of Birth:		_	Age: I		mail:	
Have you attended a seminar of Dr. Macdonald's?				Oo you have extended health coverage?		
Premium Assistance YesNoCare Card#						
How did you hear about us?						
Medications:						
Present Complaint:						
Pain or problem started on						
Pains are: Sharp □ Dull □			Constant □	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?						
<u> </u>						
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	
<u></u>	Tension	<u> </u>	Fatigue		Hands Cold	
	Irritability		Depression		Stomach Upset	
	Chest Pains	<u></u>	Lights Bothers Eyes		Constipation	
	Dizziness		Loss of Memory		Cold Sweats	

Completely Interferes

Patient Pain Assessment

Name: __ Last First Date 0-10 Numeric Pain Intensity Scale (1) $\frac{1}{2}$ 0 No Mild Moderate Severe Very Intolerable Pain Pain Pain Pain Severe Pain 1) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 2 weeks. 7 0 1 2 3 4 5 6 8 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. 1 2 3 5 6 7 10 No Pain Intolerable Pain 3) Please rate your pain by circling the one number that best describes your pain on the AVERAGE. 2 3 5 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 2 3 5 7 8 6 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 24 hours, pain has interfered with your: **A.** General activity 2 3 5 6 7 8 10 Does not Interfere Completely Interferes **B.** Walking ability 3 7 8 2 5 6 10 Does not Interfere Completely Interferes **C.** Normal work (includes both work outside the home and housework) 3 2 5 6 7 8 10 Does not Interfere Completely Interferes D. Sleep 0 9 1 2 3 4 5 6 7 8 10 Does not Interfere Completely Interferes E. Enjoyment of life 8 2 3 5 7 10 4 6

Does not Interfere