INTEGRATED
PAIN AND NEUROSCIENCE

NAME: _____

DATE_____

DATE OF BIRTH: _____

* 5121535w6546 E-HealthHx

Rate your pain: (Circle words and numbers that describe your experience)

Usually: 0 1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

Are you currently experiencing any of these symptoms? (Please circle any that apply)

Constitutional:	Fever	Significant Weight Gain:_____lbs	Significant Weight Loss:_____lbs	Exercise Intolerance
Eyes:	Dry Eyes	Irritation	Vision Change	
Ears:	Difficulty Hearing	Ear Pain		
Nose:	Frequent Nosebleeds	Sinus Problems		
Mouth/Throat:	Sore Throat	Bleeding Gums	Dry Mouth	Teeth Problems
Cardiovascular:	Chest Pain	Arm pain on exertion	Shortness of breath when walking	Shortness of breath when lying down
	Palpitations	Known heart murmur		
Respiratory:	Cough	Wheezing	Shortness of breath	Coughing up blood
GI:	Abdominal Pain	Vomiting	Change in appetite	Frequent Diarrhea
	Vomiting blood	Constipation		
	Nausea		Blood in stool	Ulcer Disease
Genitourinary:	Incontinence	Difficulty urinating	Blood in urine	Increased frequency
Musculoskeletal:	Muscle aches	Muscle weakness	Joint pain	Back pain
	Extremity swelling			
Skin:	Jaundice	Rash	Itching	Growths/Sores
Neurologic:	Weakness	Numbness	Seizures	Dizziness
	Frequent Headaches	Drowsiness		
Psychiatric:	Depression	Sleep disturbances	Anxiety	Suicidal thoughts
Endocrine:	Fatigue	Increased thirst	Hair loss	
Hematologic	Swollen glands	Easy bruising		
Allergy/Immune	Runny nose	Sinus pressure	Hives	Frequent Sneezing