INTEGRATED
PAIN AND NEUROSCIENCE

NAME:
DATE
DATE OF BIRTH:

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 ☐