PATIENT STATUS FORM

NAME _____ DATE _____ MSG DDG

WHERE is your current pain or symptoms? _____

_____

HOW did your current pain or symptoms start? _____

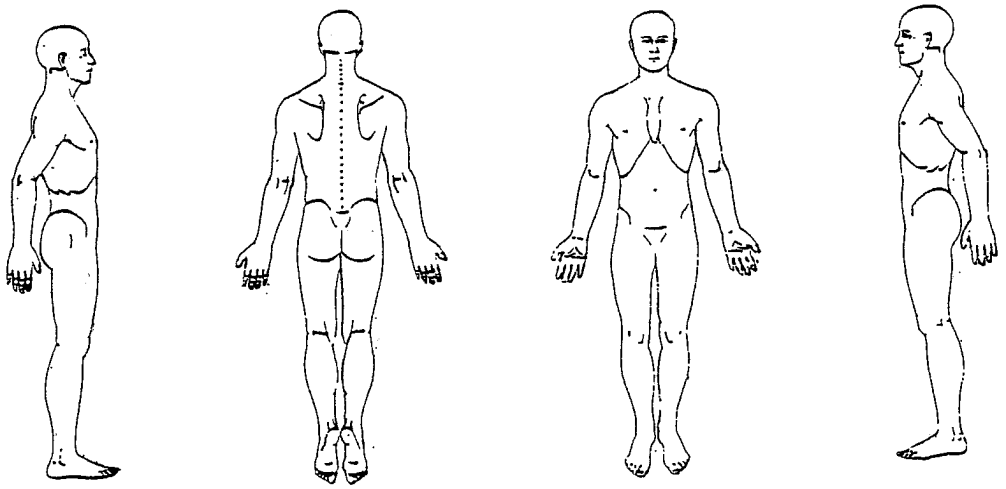
_____

WHEN did this condition start - onset date? _____

Is this condition due to an ☐ Auto Accident ☐ Work Injury ☐ Slip / Fall ☐ Unknown ☐ Other

	No Pain/Symptoms										Unbearable Pain/Symptoms
Rate the pain/symptoms you have right **NOW**:	0	1	2	3	4	5	6	7	8	9	10
Rate your pain/symptoms at its **BEST** in the past week:	0	1	2	3	4	5	6	7	8	9	10
Rate your **WORST** pain/symptoms the past week:	0	1	2	3	4	5	6	7	8	9	10

Circle ALL areas of pain or discomfort



Tobacco User? ☐ No ☐ Former User ☐ Yes _____ Amount per day

Are you allergic to any medications? ☐ No ☐ Yes _____

_____

Medications:

	Name	Dose	Frequency
☐ None			
☐ Listed			
☐ See Attached			

PLEASE ADVISE OF ANY CHANGES IN THE FOLLOWING INFORMATION: ☐ No Change

Address: _____ City / State / Zip: _____

Telephone: _____ Employer: _____

INSURANCE: Please give the receptionist your new insurance card

I understand the above information was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information provided on this form or any changes in my medical status.

Patient's Signature (or guardian): _____ Date: _____