MAINE OSTEOPATHIC HEALTH

# New Patient Form

**Patient Name:** _____ **Date of Birth:** _____ **Today's Date:** _____

Circle the number that best describes your pain at its **WORST** in the last month or since your last visit:

**No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

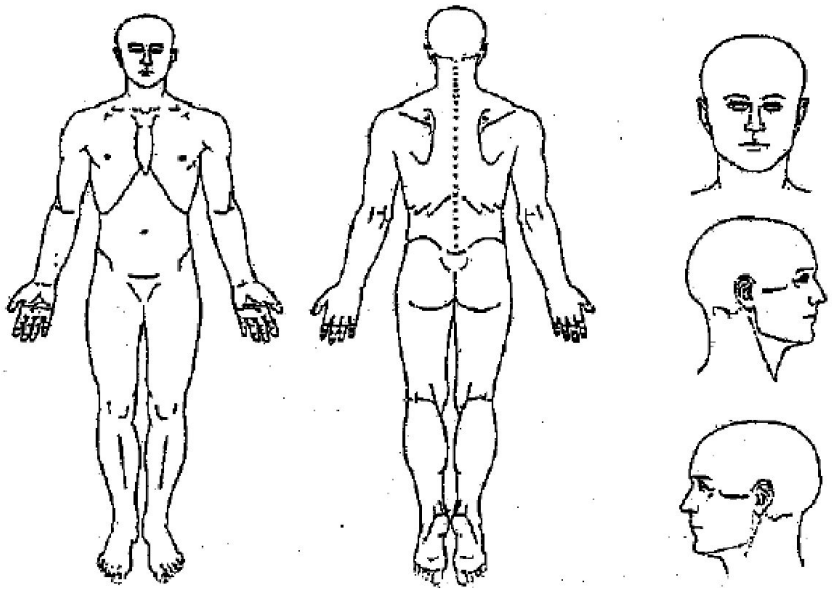
Circle the number that best describes your pain at its **LEAST** in the last month or since your last visit:

**No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Circle the number that describes your pain **RIGHT NOW**:

**No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

On the Diagram below, **shade** the areas where you feel pain. Mark an "X" over the area(s) with the worst pain.



**Circle the words that describe your pain:**

| | |
|---|---|
| Aching | Shooting |
| Sharp | Stabbing |
| Penetrating | Intermittent |
| Continuous | Gnawing |
| Tiring | Burning |
| Tender | Throbbing |
| Nagging | Exhausting |
| Tingling | Numb |
| Miserable | Unbearable |

What makes the pain **better**?

What makes the pain **worse**?

How much pain has interfered with your normal activity? Not at all A little bit Quite a bit Severely

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How would you describe your sleep habits? Excellent Good Fair Poor

Have you noticed any of the following:

(1) Changes in bowel or bladder function (control)? Yes No

(2) Swelling in joints? Yes No

(3) Numbness or tingling in the arms or legs? Yes No

(4) Changes in strength in the arms or legs? Yes No

Do you use tobacco products?

What have you been doing for exercise?

What treatments have you had since your last visit?

Chiropractic Physical Therapy Acupuncture Injections Surgery Medications

Please list any new over-the-counter or prescription medications, supplements or herbal remedies: