Premier Pain Institute

Minimally Invasive Interventions for Spinal and Sports Injury

Phone: (480) 314-2288 Fax: (480) 314-1113

Date:______________

For Office Use Only:

HT:________ **WT:**________ **B/P:**________ **Pulse:**________

Temp:_______ **RR:**________ **Sp02:**________

Patient Assessment

To be completed by patient:

Name:____________________ **DOB:**__________ **Referring Doctor:**____________________

1. Please rate your pain compared to before your start of treatment.

   Major Pain: _______ Increased _______ Decreased _____Unchanged

   Please rate your pain level on a scale from 0 to 10.

   0 = No pain at all 10 = Intolerable pain

   What is your pain level today?_____ (0-10)

2. Please rate your mobility compared to before your start of treatment.

   Mobility: ______Increased _______Decreased _______Unchanged

3. Please rate your overall ability to function compared to before your start of treatment.

   Comfort and overall function: _____Increased _______Decreased _______Unchanged

4. Please rate your overall Numbness and Tingling compared to before your start of treatment.

   Numbness and Tingling: ________Increased _______Decreased _______Unchanged

Medication reviewed/updated:

☐ **No Change** ☐ **Following Changes**

Please list ALL medication changes: ______________________________

____

History & Physical reviewed/updated:

☐ **No Change** ☐ **Following Changes** ______________________________

____

Plan of treatment: (For Doctor Use Only): ______________________________

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