



A.A Specialty Health Center  
A.A. Pain Clinic

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

(PLEASE NOTE: This form must be completed thoroughly before seeing the physician.)

What are we seeing you for today? \_\_\_\_\_

Do you have any relatives, care givers, or significant others that are also patients here?

\_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_

Where do you get your pain medications filled? \_\_\_\_\_

What are the major areas of pain on your body? \_\_\_\_\_

Is the pain constant, periodic, or a new pain? \_\_\_\_\_

What is the highest level of pain for this last month? 0 1 2 3 4 5 6 7 8 9 10

What is the lowest level of pain for this last month? 0 1 2 3 4 5 6 7 8 9 10

What makes your pain worse? \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

What words would you use to best describe your pain? \_\_\_\_\_

What time do you go to bed at night? \_\_\_\_\_ What time do you get up? \_\_\_\_\_

Do you have difficulty falling asleep? YES NO Difficulty waking up? YES NO

Is your sleep broken during the night for pain \_\_\_\_ bathroom \_\_\_\_ or both \_\_\_\_?

Are you tired during the day? YES NO do you take naps? YES NO

Do your legs feel restless during the day \_\_\_\_ night \_\_\_\_ or both \_\_\_\_?

How many times do you wake at night to urinate? \_\_\_\_\_

When you cough or sneeze do you lose urine? YES NO

Do you have constipation? YES NO

Have you had any problems or issues with your pump or stimulator? \_\_\_\_\_

When was your last procedure or surgery by any physician? \_\_\_\_\_

When was your last doctor visit outside of our clinic? \_\_\_\_\_ Which doctor? \_\_\_\_\_

Have you been on any antibiotics recently? \_\_\_\_\_

Please list ALL medications taken in the past 24 hours. Please include all prescriptions (even those not in pill form) over the counter medication, vitamins, and herbal supplements. Your list should include any medications prescribed by your primary physician. (I.e. diabetic meds, blood pressure meds, anxiety meds, birth control, etc.) \_\_\_\_\_

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