NATURAL HEALING FAMILY MEDICINE
LORI WIESER N.D.
NATUROPATHIC PHYSICIAN

PAIN TREATMENT EXTRA PAIN AREAS 4,5,6

Last Name:_____ First Name:_____ Date:_____/_____/_____
DOB:_____/_____/_____ Gender:_____

PAIN/INJURY #4 Chief Complaint:

□ Work Related Injury	□ Recreational Injury	□ Motor Vehicle Injury	□ Sports Injury	□ Pain Management	□ Other_____

□ Acute (less than 30 days) □ Subacute (1 - 6 months) □ Chronic (more than 6 months)

Approx date/time of injury:

What caused the injury/pain:_____

How did your current episode begin? □ Suddenly □ Gradually

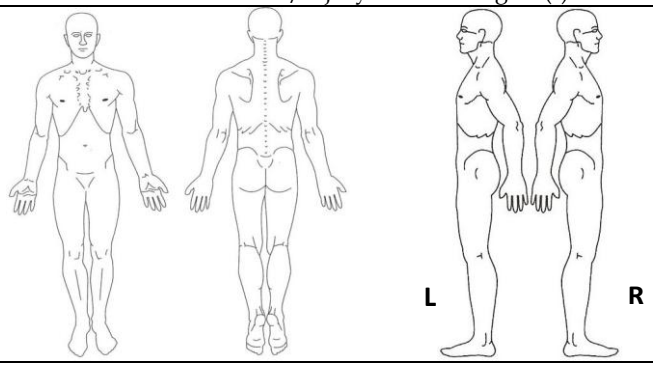
Check all that apply

My pain is: □ Numb □ Throbbing □ Aching □ Burning □ Stabbing □ Dull
□ Shooting □ Sharp □ Cramping □ Tingling □ Radiating (where):_____

What makes it better (rest, massage):_____
What makes it worse (work, exercise):_____

Has your current pain gotten: □ Better □ Worse □ Unchanged

Please circle the area of Pain/Injury #4 on the figure(s) below



Please circle the number which best describes Pain/Injury #1. **0** is NO PAIN - **10** is THE MOST PAIN YOU HAVE EVER BEEN IN

What is your pain right now?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
What is your typical or average pain?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

HISTORY OF IMAGING: Please select each box that applies to Pain/Injury #4

□ X-Ray □ MRI □ Ultrasound □ CT □ EMG (nerve conduction study)

HISTORY OF TREATMENT

Please select each method of treatment that applies to Pain/Injury #4. Mark "C" if you are CURRENTLY using this method, mark "P" if you have used the method in the PAST ". In the "Improvement Rating" section please rate with 1=Better, 2=No Change, 3=Worse

P	C	METHOD	FREQUENCY/ # OF TIMES	IMPROVEMENT RATING
□	□	Primary Care Physician		
□	□	Chiropractic		
□	□	Massage		
□	□	Physical Therapy		
□	□	Acupuncture		
□	□	Yoga/Exercise		
□	□	Surgery		
□	□	Ultrasound		
□	□	Brace/Splint		

□	□	Joint Injections:where_____		
□	□	Trigger Point Injections:where_____		
□	□	Epidural Injection (spinal cord)		
□	□	Surgery:where_____		
□	□	Radiofrequency Ablations		
□	□	Over-the-counter medications		
□	□	Prescription Medications		
□	□	Vitamins/Herbs		
□	□	Other:_____		

If you have copies of your imaging results (ie: MRI, X-Ray, CT Scan), please bring to the visit.

Below please list your Activity of Daily Life (ADL) **MOST AFFECTED** by Pain/Injury #4.
Helping this ADL will be our primary goal. (ADL: brush teeth, tie shoes, walk, pick up kids)

ADL:

Do you need medication(s) to perform this ADL? □ No □ Yes_____

Goals for ADL:_____

PAIN/INJURY #5 Chief Complaint:

□ Work Related Injury	□ Recreational Injury	□ Motor Vehicle Injury	□ Sports Injury	□ Pain Management	□ Other_____

□ Acute (less than 30 days) □ Subacute (1 - 6 months) □ Chronic (more than 6 months)

Approx date/time of injury:

What caused the injury/pain:_____

How did your current episode begin? □ Suddenly □ Gradually

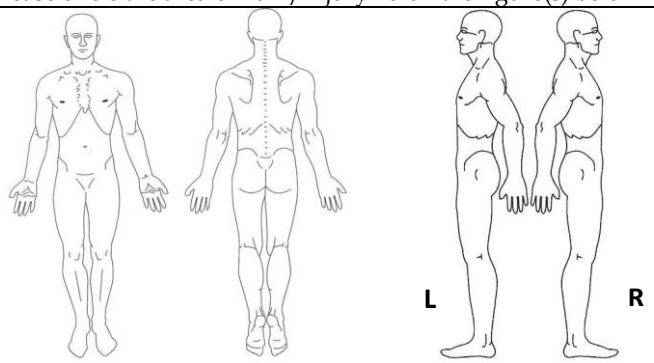
Check all that apply

My pain is: □ Numb □ Throbbing □ Aching □ Burning □ Stabbing □ Dull
□ Shooting □ Sharp □ Cramping □ Tingling □ Radiating (where):_____

What makes it better (rest, massage):_____
What makes it worse (work, exercise):_____

Has your current pain gotten: □ Better □ Worse □ Unchanged

Please circle the area of Pain/Injury #5 on the figure(s) below



Please circle the number which best describes Pain/Injury #5. **0** is NO PAIN - **10** is THE MOST PAIN YOU HAVE EVER BEEN IN

What is your pain right now?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
What is your typical or average pain?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

HISTORY OF IMAGING: Please select each box that applies to Pain/Injury #5

□ X-Ray □ MRI □ Ultrasound □ CT □ EMG (nerve conduction study)

HISTORY OF TREATMENT

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Please select each method of treatment that applies to Pain/Injury #5. Mark "C" if you are CURRENTLY using this method, mark "P" if you have used the method in the PAST ". In the "Improvement Rating" section please rate with 1=Better, 2=No Change, 3=Worse

P	C	METHOD	FREQUENCY/ # OF TIMES	IMPROVEMENT RATING
□	□	Primary Care Physician		
□	□	Chiropractic		
□	□	Massage		
□	□	Physical Therapy		
□	□	Acupuncture		
□	□	Yoga/Exercise		
□	□	Surgery		
□	□	Ultrasound		
□	□	Brace/Splint		
□	□	Joint Injections:where_____		
□	□	Trigger Point Injections:where_____		
□	□	Epidural Injection (spinal cord)		
□	□	Surgery:where_____		
□	□	Radiofrequency Ablations		
□	□	Over-the-counter medications		
□	□	Prescription Medications		
□	□	Vitamins/Herbs		
□	□	Other:_____		

If you have copies of your imaging results (ie: MRI, X-Ray, CT Scan), please bring to the visit.

Below please list your Activity of Daily Life (ADL) **MOST AFFECTED** by Pain/Injury #5.
Helping this ADL will be our primary goal. (ADL: brush teeth, tie shoes, walk, pick up kids)

ADL:

Do you need medication(s) to perform this ADL? □ No □ Yes_____

Goals for ADL:_____

PAIN/INJURY #6 Chief Complaint:

□ Work Related Injury	□ Recreational Injury	□ Motor Vehicle Injury	□ Sports Injury	□ Pain Management	□ Other_____

□ Acute (less than 30 days) □ Subacute (1 - 6 months) □ Chronic (more than 6 months)

Approx date/time of injury:

What caused the injury/pain:_____

How did your current episode begin? □ Suddenly □ Gradually

Check all that apply

My pain is: □ Numb □ Throbbing □ Aching □ Burning □ Stabbing □ Dull
□ Shooting □ Sharp □ Cramping □ Tingling □ Radiating (where):_____

What makes it better (rest, massage):_____

What makes it worse (work, exercise):_____

Has your current pain gotten: □ Better □ Worse □ Unchanged

Please circle the area of Pain/Injury #6 on the figure(s) below

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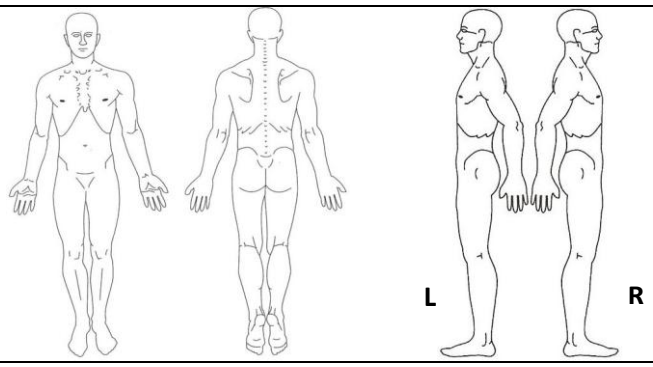

Please circle the number which best describes Pain/Injury #6. **0** is NO PAIN - **10** is THE MOST PAIN YOU HAVE EVER BEEN IN

What is your pain right now?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
What is your typical or average pain?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

HISTORY OF IMAGING: Please select each box that applies to Pain/Injury #6

☐ X-Ray ☐ MRI ☐ Ultrasound ☐ CT ☐ EMG (nerve conduction study)

HISTORY OF TREATMENT

Please select each method of treatment that applies to Pain/Injury #6. Mark "C" if you are CURRENTLY using this method, mark "P" if you have used the method in the PAST ". In the "Improvement Rating" section please rate with 1=Better, 2=No Change, 3=Worse

P	C	METHOD	FREQUENCY/ # OF TIMES	IMPROVEMENT RATING
☐	☐	Primary Care Physician		
☐	☐	Chiropractic		
☐	☐	Massage		
☐	☐	Physical Therapy		
☐	☐	Acupuncture		
☐	☐	Yoga/Exercise		
☐	☐	Surgery		
☐	☐	Ultrasound		
☐	☐	Brace/Splint		
☐	☐	Joint Injections:where_____		
☐	☐	Trigger Point Injections:where_____		
☐	☐	Epidural Injection (spinal cord)		
☐	☐	Surgery:where_____		
☐	☐	Radiofrequency Ablations		
☐	☐	Over-the-counter medications		
☐	☐	Prescription Medications		
☐	☐	Vitamins/Herbs		
☐	☐	Other:_____		

If you have copies of your imaging results (ie: MRI, X-Ray, CT Scan), please bring to the visit.

Below please list your Activity of Daily Life (ADL) **MOST AFFECTED** by Pain/Injury #6.
Helping this ADL will be our primary goal. (ADL: brush teeth, tie shoes, walk, pick up kids)

ADL:

Do you need medication(s) to perform this ADL? ☐ No ☐ Yes_____

Goals for ADL:_____

If you have more than 6 issues you would like to bring to Dr. Wieser's attention, please fill out NHFM Pain Treatment Extra Pain Areas 7,8,9 (located at naturalhealingfamilymedicine.com), and bring it to your first visit.

Located at : Trinity Massage and Wellness

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