CSN - RETURN
PATIENT INFORMATION QUESTIONAIRE

Name _____ *DOB:*

Has your pain changed since last visit?_____

Circle the words below that describe your pain:

Burning	Aching	Sharp	Constant
Electric	Throbbing	Stabbing	Occasional
Prickling	Dull	Shooting	Frequent
Numbing	Cramping	Stinging	Rare

Pain **with** medications/therapy:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain

Pain **without** medications/therapy:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain

Review of Systems

Circle all past/present symptoms:

Constitutional:
Appetite Change | Chills | Sweating
Fever | Fatigue | Weight Change

HENT
Neck pain | Neck Stiffness | Ear Pain
Sore Throat | Congestion | Sinus Pressure

Eyes:
Eye Pain | Blurred Vision | Double Vision

Respiratory:
Apnea | Shortness of breath | Cough

Cardiovascular:
Chest pain | Swelling | Palpitations

Gastrointestinal:
Nausea/Vomiting | Constipation | Diarrhea

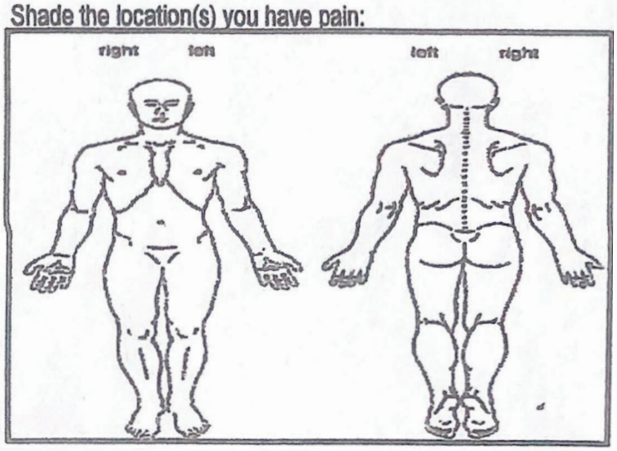
Endocrine:
Thyroid problems | Elevated glucose | Sexual difficulties

Genitourinary:
Incontinence | Hesitancy | Urgency

Musculoskeletal:
Arthralgia | Back Pain | Gait Disturbance

Skin:
Color Changes | Rash | wounds

Shade the location(s) you have pain:



Past Medical History- Update

List new allergies:_____

Work Status:_____

Any changes with your health since last visit_____

List changes in medications since last visit_____

Circle the number to describe your average daily function

0 1 2 3 4 5 6 7 8 9 10

None — Full

Allergy/Immunology:
Immunocompromised | Food allergies | Recent infection

Neuro:
Headache | Dizziness | Numbness
Weakness | Confusion | Seizures

Hematologic:
Anticoagulation | HIV | Bleeding disorder

Psychiatric:
Depression/anxiety | Substance abuse | Suicidal thoughts

Provider Notes

HR:____ BP:____ RR:____ Sat____ Wt____ T____