P A L M B E A C H S P I N E & D I A G N O S T I C I N S T I T U T E
M E D I C A L S T A T U S U P D A T E
& P A I N A S S E S S M E N T F O R M

Date: _____ **ASA : 1 2 3**

Name: _____ Age: _____ Height: _____ Weight: _____

Has your Insurance, Address, or Phone number changed? (Circle Yes or No)
If you answered yes, please provide new information here. _____
_____

Have you been hospitalized or had a change in your health since your last visit? (Circle Yes or No)
If you answered yes, please explain. _____
_____

List all of your current medications: (including over the counter medication, vitamins/herbs)

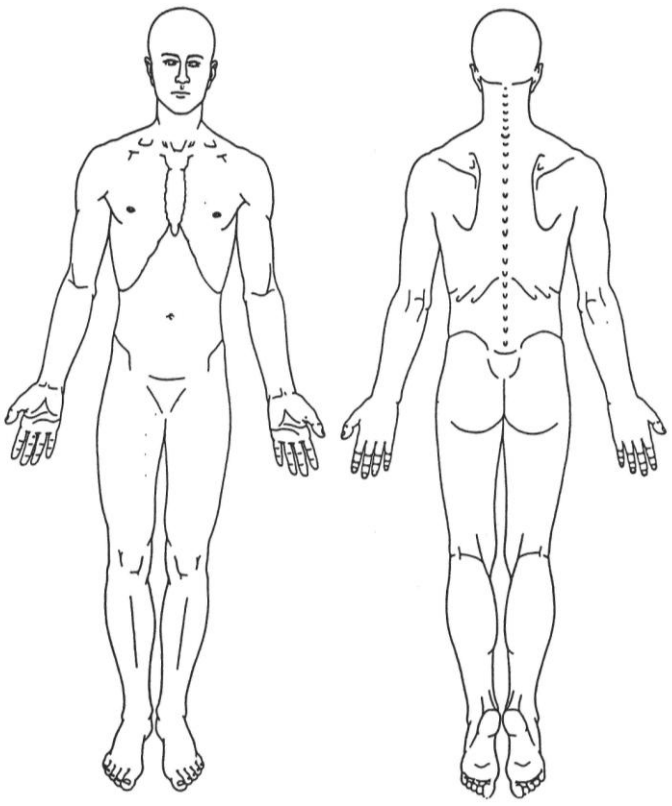
Please List ANY allergies: _____

Describe reason for visit today: _____

What makes the pain worse? _____

What makes the pain better? _____

What have you tried to relieve the pain? _____



Indicate on the picture below where you feel the following sensations:
^^^ ache ○○○ numbness ●●● pins & needles
xxx burning /// stabbing

Indicate the severity of your pain by marking an "X' on the appropriate number. How bad is the pain right now?

0-----1-----2-----3-----4-----5-----6-----7-----8-----9----10
no pain moderate severe

Signature: _____

Nurse: _____

Doctor: _____