Innovative Pain Care Center

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PainFreeNevada.com

Office Use Only UA
Self Pay, MCare – NO Bill
LC-NO Bill
Quest, or CPL-80305
Lien - 00000

OFFICE VISIT

Patient (Print) _____ **Date** _____

Date of Birth _____ **Insurance Provider** _____

Cell Number _____ **Home Number** _____ **Email** _____

Pharmacy Name _____ **Phone Number** _____

Check the number that best describes your pain **AT ITS WORST** since last visit:

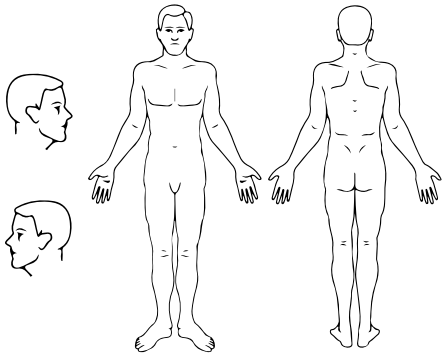
0	1	2	3	4	5	6	7	8	9	10
None					Moderate					Severe

Check the number that best describes your pain **ON AVERAGE** since last visit:

0	1	2	3	4	5	6	7	8	9	10
None					Moderate					Severe

LIST MEDICATIONS PRESCRIBED BY THIS OFFICE:

Medication	Dosage (mg)	Times/Day	Date & Time Last Dose



(Mark the location of your pain on the figure)

What medications are you currently requesting?_____

Have you seen any other doctors or had any testing since your last visit (MRI, C.T., X-Ray, and/or Nerve Conduction Studies) ☐ Yes ☐ No _____

Any new symptoms (pain, weakness, numbness, bowel or bladder dysfunction, etc.)_____

To Be Completed by Staff: HT _____ WT _____ R _____ BP _____ P _____

Procedure Follow-up: % of Relief:_____% Duration: _____ Current Relief: _____%

Treatment Plan:

1. Follow-up visit in ___ weeks w/ ☐ Burkhead ☐ Wu ☐ West ☐ Scott ☐ Jones ☐ Kelsee
2. Procedure: _____

   ☐ Diabetic ☐ MRSA ☐ SHINGLES ☐ ASA ☐ NSAID's ☐ Coumadin ☐ Plavix ☐ Other _____

   Tests Performed: ☐ MRSA Screen ☐ UA/RDS
3. ☐ PT ☐ Chiro ☐ Radiology Specialist Refer to: _____

Practitioner Signature _____