**MEDICAL PROGRESS NOTE**

**WHAT TYPE OF VISIT ARE YOU HERE FOR TODAY?**

- [ ] FOLLOW UP VISIT
- [ ] PROCEDURE

**WORKERS COMP PATIENTS ONLY** (Please complete this section if you are here for a Workers Comp visit today.)

**CURRENT WORK STATUS:**
- [ ] Fulltime
- [ ] Part-time (____ hours/week)
- [ ] Not currently employed
- [ ] Retired

**IS YOUR CASE IN DISPUTE?**
- [ ] YES
- [ ] NO

**OCCUPATION:**

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**SECTION 1: CURRENT PAIN LEVEL**

Using the chart below, answer each question by circling the number that corresponds with your pain level.

<table>
<thead>
<tr>
<th>Does not interfere with activities</th>
<th>Mildly interferes with activities</th>
<th>Somewhat interferes with activities</th>
<th>Partially interferes with activities</th>
<th>Greatly interferes with activities</th>
<th>Completely interferes with activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**PAIN SCALE**

- [ ] 0
- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] 6
- [ ] 7
- [ ] 8
- [ ] 9
- [ ] 10

Current pain level. Do Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

Average pain level since last visit. Do Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

Pain level at its worst. Do Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

Pain level at its least. Do Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

Rate your ability to:

- Sleep: Do Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes
- Manage activities that require standing: Do Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes
- Manage activities that require walking: Do Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes
- Manage activities that require sitting: Do Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes
- Manage your daily responsibilities: Do Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes
- Manage your hobbies and/or recreational activities: Do Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

Choosing one from the following activities, rate your ability to do: Do Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

- [ ] work
- [ ] housework
- [ ] gardening/yard work
- [ ] play with children
- [ ] driving
- [ ] exercise
- [ ] sports/golf
- [ ] intimacy

**WORK STATUS** (if not Workers Comp):[ ] Full Time [ ] Part Time (___ hrs/wk) [ ] Not currently employed [ ] Retired

**OCCUPATION:**

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**WHERE IS YOUR PAIN PRIMARILY LOCATED?** (Please draw & shade on diagram.)

- [ ] Head
- [ ] Neck
- [ ] Upper-Mid Back
- [ ] Right Arm
- [ ] Left Arm
- [ ] Mid-Back Pain
- [ ] Lower Back
- [ ] Abdomen
- [ ] Pain in the Tailbone
- [ ] Other:

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**HOW WOULD YOU DESCRIBE YOUR PAIN?** (Please draw all that apply.)

- [ ] Burning
- [ ] Shooting
- [ ] Throbbing
- [ ] Cramping
- [ ] Aching
- [ ] Constant
- [ ] Sharp
- [ ] Dull
- [ ] Intermittent
- [ ] Other:
SECTION 1: CURRENT PAIN LEVEL (continued)

**PAIN INCREASES WITH:**
- Walking
- Sitting
- Standing
- Activity
- Other: ___________________________

**PAIN DECREASES WITH:**
- Rest
- Lying Down
- Heat
- Cold
- Other: ___________________________

DO YOU USE ANY ASSISTIVE DEVICES?  
- None
- Wheelchair
- Cane
- Walker
- Crutches
- Prosthesis
- Other

IS YOUR PAIN LEVEL BETTER SINCE YOUR LAST VISIT?  
- Yes
- No
- Same

IF YOU HAD AN INJECTION ON YOUR LAST VISIT, DID IT DECREASE YOUR PAIN?  
- 0%
- 25%
- 50%
- 75%
- More than 75%

HOW WELL DO YOU SLEEP?  
- 0-4 hrs/night
- 4-6 hrs/night
- 6-8 hrs/night
- Restful
- Disruptive
- Pain Related

HAVE YOU HAD ANY NEW SIDE EFFECTS? (If yes, please specify) ___________________________

SECTION 2: CURRENT SYMPTOMS (Please indicate Yes or No for each symptom.)

<table>
<thead>
<tr>
<th>Constitutional</th>
<th>Eyes</th>
<th>ENT</th>
<th>Cardiovascular</th>
<th>Respiratory</th>
<th>Gastrointestinal</th>
<th>Genitourinary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y N Fever</td>
<td>Y N</td>
<td></td>
<td>Y N Chest Pain</td>
<td>Y N Shortness of Breath</td>
<td>Y N Abdominal Pain</td>
<td>Y N Painful Urination (Dysuria)</td>
</tr>
<tr>
<td>Y N Chills</td>
<td></td>
<td>Y N</td>
<td>Y N Palpitations</td>
<td>Y N Cough</td>
<td>Y N Constipation</td>
<td>Y N Urinary Retention</td>
</tr>
<tr>
<td>Y N Feeling Poorly (Malaise)</td>
<td>Y N</td>
<td>Y N</td>
<td>Y N Heart Rate is Slow</td>
<td>Y N Wheezing</td>
<td>Y N Diarrhea</td>
<td>Y N Vaginal Discharge</td>
</tr>
<tr>
<td></td>
<td>Y N</td>
<td>Y N</td>
<td>Y N Leg Pain w/Exercise (Leg Claudication)</td>
<td>Y N Cough Worse at Night</td>
<td>Y N Pelvic Pain</td>
<td>Y N Nausea</td>
</tr>
</tbody>
</table>

(CONTINUED ON NEXT PAGE)
SECTION 2: CURRENT SYMPTOMS (CONTINUED) (Please indicate Yes or No for each symptom.)

Musculoskeletal
- Joint Pain (Arthralgias): Y
- Muscle Pain (Myalgias): Y
- Back Pain: Y
- Neck Pain: Y
- Joint Swelling: Y
- Limb Pain: Y
- Limb Swelling: Y

Integumentary
- Skin Rash: Y
- Hives: Y
- Itching (Pruritus): Y
- Dry Skin: Y
- Hair Loss: Y
- Skin Wound(s): Y

Neurological
- Headache: Y
- Confusion: Y
- Convulsions: Y
- Significant Head Injury: Y
- Memory Lapses/Loss: Y
- Numbness: Y
- Tingling: Y
- Tremor: Y
- Limb Weakness: Y
- Dizziness: Y
- Excessive Sleepiness During the Day (Daytime Somnolence): Y

Psychiatric
- Suicidal: Y
- Sleep Disturbances: Y
- Crying Spells: Y
- Depression: Y
- Emotional Problems: Y

Endocrine
- Hot Flashes: Y
- Excessive Sweating: Y
- Deepening of the Voice: Y
- Excessive Thirst (Polydipsia): Y

Heme/Lymph
- Swollen Glands: Y
- Easy Bruising: Y

SECTION 3: CHANGES IN MEDICATIONS (Please list any changes in your medications since your last visit.)

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
<th>DATE</th>
<th>MEDICATIONS</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECTION 4: PROCEDURES (If you are having a procedure today, please indicate yes or no to the following questions.)

Y N
- Do you have any **active infections** or are you on **antibiotics** at this time?
- Are you **pregnant**?
- Are you **allergic** to **shellfish** or **IV contrast**?
- Are you a **diabetic**?
- Are you taking any **anticoagulants** (blood thinners), such as Aspirin, Coumadin, fish oil, etc.?