Thank you for choosing Integrated Provider Group of Minnesota

Please take a few minutes to fill out this paperwork before we begin your appointment. If there are any questions that do not apply or you do not feel comfortable answering please skip them – if you have any questions please do not hesitate to ask!

NAME: _____ **DOB:** _____

Reason for today's visit: _____

❒new injury ❒old injury (flare up) ❒chronic pain (greater than 3 months)

❒motor vehicle accident ❒at work ❒other _____

When did this start: _____

How did this start: _____

Using a scale from 1-10 (10 being the worst), rate your symptom(s) at its *worst*:

0 1 2 3 4 5 6 7 8 9 10

Using a scale from 1-10 (0 being the best), rate your symptom(s) at its *best*:

0 1 2 3 4 5 6 7 8 9 10

What makes your symptom(s) worse: _____

What makes your symptom(s) better: _____

How frequent are you having your symptom(s):

❒constant ❒frequent ❒occasional ❒comes and goes

Do you feel that your symptom(s) is:

❒getting worse ❒getting better ❒staying the same

Have you had similar symptom(s) in the past? _____

Who else have you seen for the symptom(s) and what was the treatment?

_____

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

P – pain
N – numbness
W – weakness
S – shooting
A - aching