Integrative PAIN CLINIC

Patient Name:_____ **DOB:**_____ **Today's Date:** _____

REVIEW OF SYSTEMS: ☐ **EVERYTHING NORMAL**

GENERAL: ☐ FATIGUE ☐ WEIGHT LOSS ☐ WEIGHT GAIN ☐ FEVER

SKIN: ☐ RASH ☐ ITCHING

EYES: ☐ BLURRED VISION ☐ DOUBLE VISION ☐ ITCHING ☐ WATERING

ENT: ☐ EAR PAIN ☐ DIFFICULTY HEARING ☐ RINGING ☐ NASAL CONGESTION ☐ SEASONAL ALLERGIES

CARDIOVASCULAR: ☐ CHEST PAIN ☐ PALPITATIONS ☐ SWELLING OF FEET

RESPIRATORY: ☐ COUGH ☐ SHORTNESS OF BREATH ☐ WHEEZING.

GASTROINTESTINAL: ☐ CONSTIPATION ☐ NAUSEA ☐ VOMITING ☐ DIARRHEA

GENITOURINARY: ☐ FREQUENT URINATION ☐ BURNING ☐ URGENCY ☐ BLOOD IN THE URINE

BLADDER INCONTINENCE ☐ POOR LIBIDO ☐ ERECTILE DYSFUNCTION

MUSCULOSKELETAL: ☐ JOINT PAIN ☐ JOINT SWELLING ☐ MUSCLE WEAKNESS ☐ MUSCLE SPASMS

NEUROLOGIC: ☐ HEADACHE ☐ DIZZINESS ☐ PINS AND NEEDLES ☐ NUMBNESS ☐ WEAKNESS

HEMATOLOGIC: ☐ BRUISING EASILY ☐ RECENT BLOOD TRANSFUSION

PSYCHIATRIC: ☐ DEPRESSED MOOD ☐ ANXIETY ☐ SLEEP PROBLEMS

ENDOCRINE: ☐ COLD INTOLERANCE ☐ HEAT INTOLERANCE ☐ EXCESSIVE THIRST

ANYTHING ELSE _____