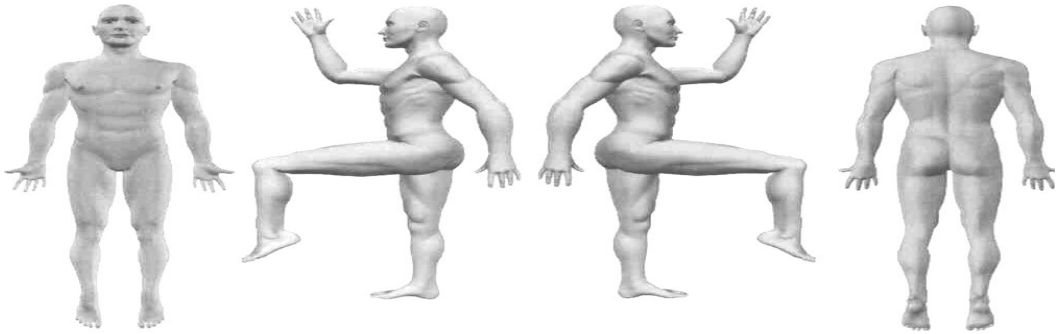
Voytik Center for Orthopedic Care (Each Visit)

Patient: _____ DOB_____

Using the diagrams below, shade all the areas of pain completely. Indicate more intense pain with darker markings.

Front Left Right Back



___ Check here If No Pain ****G8731**

___ Pain and Follow-up Plan Documented: **G8730

INTENSITY: Please circle the number that best represents your pain level.

Rate your pain **NOW**:

No pain 1 2 3 4 5 6 7 8 9 10 Worse pain

Rate your pain at its **WORSE**:

No pain 1 2 3 4 5 6 7 8 9 10 Worse pain

Rate your pain at its **BEST**:

No pain 1 2 3 4 5 6 7 8 9 10 Worse pain

***QUALITY*: Circle all the words that apply to your pain:**

Aching	Burning
Comes and Goes	Constant
Dull	Numbness
Sharp	Shooting
Stabbing	Tingling

Height _____ Foot _____ Inches Weight: _____ Total BMI:_____

****MEDICATIONS to include herbals, nutritional supplements and over-the-counter drugs.*** *****G8427*** *(130)*

Medication	Dosage	Times a Day	Oral/Topical/Injection		Medication	Dosage	Times a Day	Oral/Topical/Injection

Are you over the age of 50? ___Yes ___ No If yes, are we currently treating you for a fracture? ___Yes ___ No

**5015F (24) Communication sent to Primary Care

**5015F -8P modifier not communicated-reason not otherwise specified.

******** REQUIRED*****MUST BE COMPLETED*** Primary Care Physician _____

_____ _____ _____

Patient Signature Date/Exam Date Providers Signature