CRESCENT Pain Relief

PATIENT DAILY INTAKE FORM

Current Pain Medications:

Experiencing Side Effects of Medication:
Comments (if applicable):

Patient Perception of Pain Control:

Since Last Visit Pain is:

Where is your pain primarily located?

TIMING

- ☐ Constant
- ☐ When Standing
- ☐ When Sitting
- ☐ When Laying Down
- ☐ At Work
- ☐ Other (please explain):

DURATION

- ☐ Just started
- ☐ A few weeks
- ☐ A few months
- ☐ >1 year
- ☐ Reoccurring
- ☐ Other (please explain):

RADIATION

- ☐ Down Legs
- ☐ Into Head
- ☐ Across Shoulder
- ☐ To the Back
- ☐ Reoccurring
- ☐ Other (please explain):

QUALITY

- ☐ Burning
- ☐ Continuous
- ☐ Intermittent
- ☐ Numbing
- ☐ Radiating
- ☐ Other (please explain):
- ☐ Sharp
- ☐ Stabbing
- ☐ Throbbing
- ☐ Tingling
- ☐ Weakness

PAIN GETS BETTER WITH

- ☐ Activity
- ☐ Cold
- ☐ Elevation
- ☐ Evening Time
- ☐ Other (please explain):
- ☐ Massage
- ☐ Medications
- ☐ Movement
- ☐ Morning
- ☐ Heat
- ☐ Injections
- ☐ Rest
- ☐ Surgery

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PATIENT DAILY INTAKE FORM

BRAIN WELLNESS SURVEY

Within the past 12 months: CIRCLE "Y" = Yes "N" = No	
Have you lost consciousness or fainted at any point? (R55)	**Y / N**
Have you experienced short-term or long-term memory loss? (R41.3)	**Y / N**
Have you experienced any seizures or convulsions? (G40.001 / R56.9)	**Y / N**
Have you experienced any tremors, spasms or involuntary limb movements? (R25.8)	**Y / N**
Any periods of dizziness or vertigo? (R42)	**Y / N**
Any periods of disorientation? (R41.0)	**Y / N**
Any periods of interruptions of mental awareness? (R40.4)	**Y / N**
Do you suffer from any type of post-traumatic stress (PTSD)? (F43.10)	**Y / N**
Do you have frequent or severe headaches/migraines? (G43.9 / G43.7)	**Y / N**