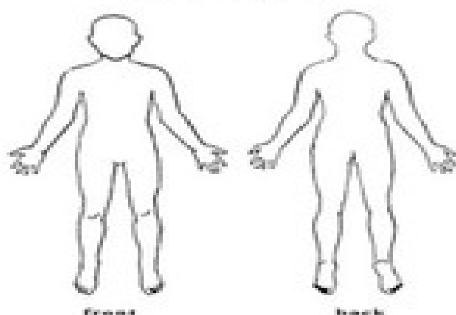
Patient Form

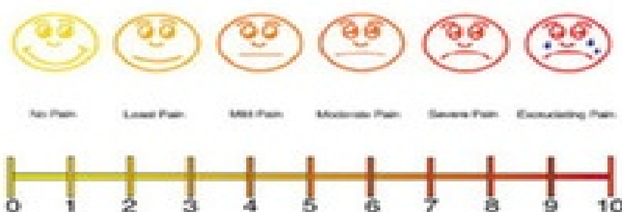
Please fill out the following form. Give the form to the Doctor when your name is called

Name of Patient:____

Please circle the parts of your body where you feel pain



On a scale of 1 to 10 how bad is the pain?



When did the pain begin?____

Please circle Y for YES or N for NO for the follwing questions:

Do you have a fever? Y N
Do you have trouble breathing? Y N
Do you have a headache? Y N
Do you have a rash? Y N If so, where?____________________
Do you feel dizzy? Y N
If yes, when? (please circle) All Day In the Morning In the Evening At Night
Are you on any medications? Y N
If yes, what kind?____
Anything else you want to tell the Doctor?________________________________
____