



MEDICAL CENTERS

6315 SPALDING DRIVE, NORCROSS, GA 30092 T:770-416-9995
 6690 ROSWELL ROAD, SANDY SPRINGS, GA 30328 T:678-999-8531

Pain and Stress Assessment

Please fill out completely.

Name _____ DOB _____ Tel(Cell) _____ (WK) _____ (HM) _____

Address _____ City _____ State _____ Zip _____

Occupation _____ # Hours Per Week Currently Working _____

Spouse's Occupation _____ # Hours Per Week Currently Working _____

Email _____

Please **ONLY** mark the main reason(s) you are here today. Circle primary complaint.

- | | | |
|---|--|--|
| <input type="checkbox"/> Lower back pain | <input type="checkbox"/> Tension across top of shoulders | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Numbness/tingling in arms/hands | <input type="checkbox"/> Sleeping problems due to pain |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Numbness/tingling in legs/feet | <input type="checkbox"/> Hip/Buttocks pain |
| <input type="checkbox"/> Joint shoulder pain | <input type="checkbox"/> Joint knee pain | <input type="checkbox"/> Joint elbow pain |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Achilles | <input type="checkbox"/> TMJ |

Which of the above is the **worst problem**? _____

How long have you had this problem (including off and on)? _____ years/months

At its worst, how bad is the pain from 1-10 (with one being no pain and ten being severe pain)? _____

Food and Chemical Sensitivity Questionnaire

Please mark any of the following symptoms that you have experienced in the past 60 days.

Digestive Symptoms	Sinus/Respiratory	Head/Ears	Emotional/Mental	Energy	Skin Disorders	Weight	Persistent canker sores
Stomach Pains	Stuffy or runny nose	Migraines	Depression	Fatigue	Eczema	Inability to lose weight	Other Symptoms
or Cramping		Headaches	Anxiety	Hyperactivity	Dermatitis	Food cravings	
Constipation	Asthma	Earaches	Mood Swings	Lethargy	Excessive Sweating	Binge eating	Joint pain
Diarrhea	Chest congestion	Ear Infection	Irritability	Restlessness	Rashes	Water retention	Arthritis
Reflux or heartburn		Chronic cough	Ringing in ears	Poor Concentration	Insomnia	Hives	Irregular heartbeat
Bloating	Wheezing						
Gas		Frequent sneezing					
Nausea or Vomiting						Itchy Eyes	Chest pains
						Watery Eyes	Muscle aches
						Sore throat	