Medicare Intake Form/Chief Complaint

Patient Name _____ Date _____

Onset

When? _____

_____

How long? _____

_____

How often? _____

_____

Provoking

What increases the pain? _____

_____

Palliative

What decreases the pain? _____

_____

Region

Where is the pain? _____

_____

Does the pain radiate/to where? _____

_____

Does the pain refer/to where? _____

_____

Medicare Intake Form/Chief Complaint (cont.)

Patient Name _____ Date _____

Severity of the pain

Level of Pain at Its Best _____

Level of Pain at Its Worst _____

Level of Pain Right Now _____

Level of Pain on Average _____

Any Associated Symptoms _____

Treatment

Past Tx _____

Current Tx Plan _____

Impact

How does the pain affect you? _____

How does the pain affect your family? _____

Medicare Treatment Form/Chief Complaint (cont.)

Treatment Goals

Patient Stated _____

_____

Are there any special concerns of your condition that I should be aware of? _____

_____

_____

Treatment Plan

_____

_____

_____

_____

I agree to the treatment plan presented by the doctor.

Patient Signature _____ *Date* _____

Doctor Signature _____ *Date* _____