Texas Pain Partners

Dr. Shaun Jackson

Procedure Day Patient Form

Patient First Name:________________________________ Patient DOB:______________________

Patient Last Name:________________________________

What is your pain status now? Worse Better Same How has it changed?_________________

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Please circle on a scale of 0 to 10: (0 is no pain………10 is the worst imaginable)

At its best	0 1 2 3 4 5 6 7 8 9 10
Most of the time	0 1 2 3 4 5 6 7 8 9 10
At its worst	0 1 2 3 4 5 6 7 8 9 10

Have you taken any of the following medications below in the past 7 days? YES (which one) NO

___ NSAID ___Blood thinner ___ Antibiotics ___ Weight loss medications ___

Please list any allergies: ____

Please list medications you are currently taking for Pain:

____

____

Please list other current medications:

____