

"Put Your Pain To Rest"



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Board Certified & Fellowship Trained In Pain Management & Board Certified In Anesthesiology

Patient Name: \_\_\_\_\_

M/F Age: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Describe your pain: \_\_\_\_\_  
\_\_\_\_\_

When did your pain begin? \_\_\_\_\_

Was there an accident? \_\_\_\_\_ Date: \_\_\_\_\_

What makes your pain worse? \_\_\_\_\_  
\_\_\_\_\_

What makes your pain better? \_\_\_\_\_  
\_\_\_\_\_

Please list the Doctors that have treated you for this complaint

Doctor: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Doctor: \_\_\_\_\_ Treatment: \_\_\_\_\_  
Doctor: \_\_\_\_\_ Treatment: \_\_\_\_\_

Date

X-Ray: \_\_\_\_\_

CT Scan: \_\_\_\_\_

MRI: \_\_\_\_\_

EMG: \_\_\_\_\_

Doctor's Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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