ITG Medication and Pain Sheet

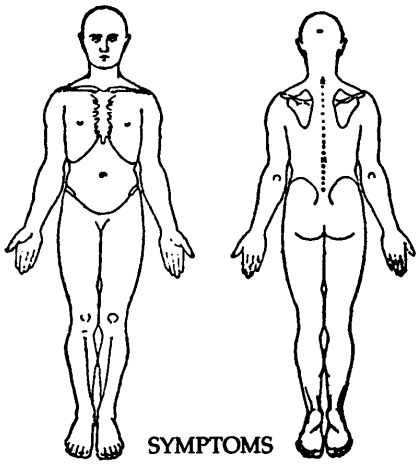
What medications are you taking now? (Including prescription and over-the-counter drugs, herbals, vitamin/ mineral/dietary (nutritional) supplements.)

❑ See Attached Med list and dosages ❑ I will bring a list to my next appointment

Medication	Dosage (How Much)	Frequency (How often)

- **Rate your pain today and locate it on the diagram**:

10 - Being the worst
9
8
7
6
5
4
3
2
1
0 - No pain at all



- **Date of injury/ surgery:_____ If not an injury, date symptoms worsened:_____**
- **Does a nurse visit your home for any reason? _____**
- **Have you had any outpatient PT or rehab services this year? _____**
- **Date of next MD appointment: _____**

I verify the medications and dosages are correct to the best of my ability.

_____ _____
Signature Date