Just in Case

Complete this form and keep it handy in case of an emergency.

Your name: ________________________ Your insurance card number: ______________________
The name of your regular healthcare provider: ____
All medical conditions: ____
List your prescription medications, over-the-counter medications, vitamins, and supplements.

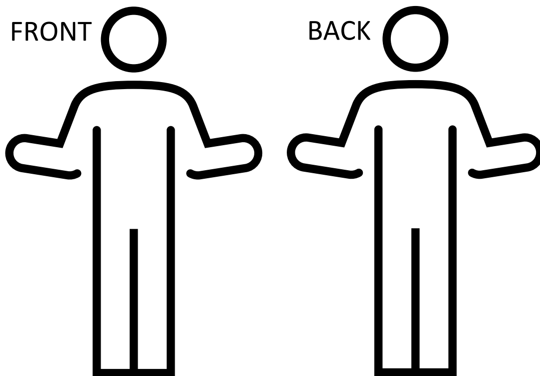
Medication	Dosage	Frequency
_____________________	_____________________	_______________________
_____________________	_____________________	_______________________
_____________________	_____________________	_______________________
_____________________	_____________________	_______________________
_____________________	_____________________	_______________________

List any devices or other types of interventions you use like pumps, nerve blocks, or stimulators.
____

List any medications you don’t tolerate well.
____

List all allergies.
____

Location of your pain. Mark where it hurts.



Intensity 1 2 3 4 5 6 7 8 9 10

When did the pain begin? ____________________
What recently aggravates your pain? __________
What helps? ________________________________
What makes it worse? _______________________
What medications have helped before? ________
____

How would you describe the pain? (Circle all that apply):

Aching	Penetrating
Nagging	Tingling
Stabbing	Throbbing
Burning	Radiating
Numb	Gnawing
Tender	Sharp