

"Put Your Pain To Rest"



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Board Certified and Fellowship Trained in
Pain Management

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: _____

Front

Back

