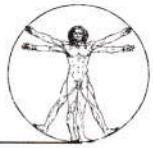
PAIN ASSESSMENT FORM



PATIENT NAME: _____ **DATE:** _____

1. HISTORY OF PAIN / SYMPTOMS

Check the folowing symptoms that you have:

- ☐ Back Pain
- ☐ Neck Pain
- ☐ Leg Pain
- ☐ Tingling/Numbness in Leg
- ☐ Arm Pain
- ☐ Tingling/Numbness in Arm
- ☐ Other

2. WHEN DID SYMPTOMS BEGIN? _____

3. HAVE YOU EVER HAD THIS PAIN BEFORE?

☐ No ☐ Yes - When? _____

4. WHAT DIAGNOSTIC TESTS HAVE YOU HAD (MRI, X-Ray, CT Scan, Etc.) **?**

_____

5. HAVE YOU EVER HAD SURGERY FOR THIS ISSUE?

☐ No ☐ Yes - What and When? _____

6. HAVE YOU HAD ANY OF THE FOLLOWING TREATMENTS FOR YOUR PAIN?

Injections: ☐ No ☐ Yes - Did it help? _____

Physical Therapy: ☐ No ☐ Yes - Did it help? _____

What type of Therapy? _____

7. WHAT MAKES YOUR PAIN BETTER? _____

8. WHAT MAKES YOUR PAIN WORSE? _____

9. DOES YOUR PAIN AFFECT ANY OF THE FOLLOWING?

- ☐ Movement
- ☐ Sleep/Rest
- ☐ Emotions
- ☐ Activities - Explain: _____
- ☐ Relationships
- ☐ Concentration
- ☐ Bowels
- ☐ Bladder
- ☐ Other - Explain: _____

10. MEDICATIONS

Have you been taking any medications for your pain? _____

_____

Have you taken medication today: ☐ No ☐ Yes - What Medication? _____

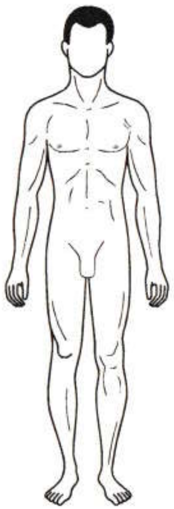
_____

11. ANY ADDITIONAL INFORMATION YOU FEEL IS IMPORTANT?

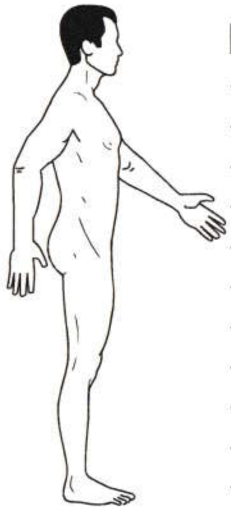
_____

_____

1. **PLACE AN X** at the location of your pain. 2. **CIRCLE THE LEVEL** of pain you experience. 3. **CIRCLE THE TYPE** of pain you are experiencing.



LEVEL	TYPE
10	Aching
9	Burning
8	Constant
7	Dull
6	Numbness
5	Sharp
4	Shooting
3	Stabbing
2	Tender
1	Throbbing
0	Tingling



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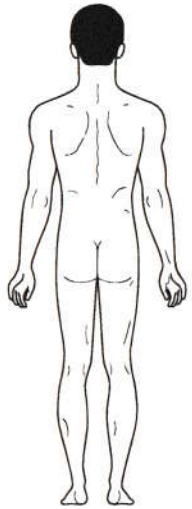

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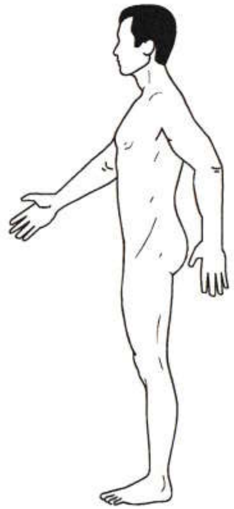

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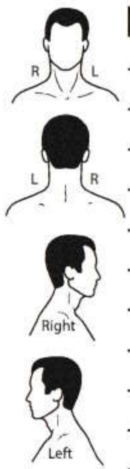

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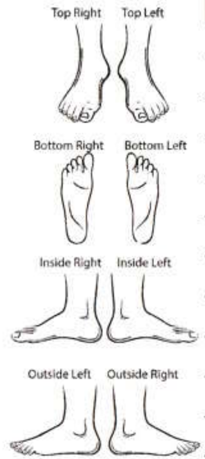

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