

PAIN ASSESSMENT FORM

Patient Name: _____

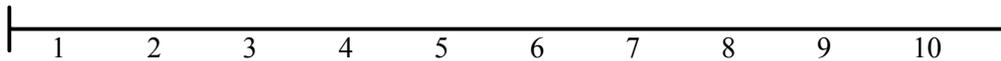
Date: _____

1. Please check the following symptoms that you have:
 back pain leg pain tingling/numbness in leg
 neck pain arm pain tingling/numbness in arm
2. When did your symptoms begin? _____
3. Are you experiencing any problems controlling your bladder or bowel?
Bowel: Yes No
Bladder: Yes No
4. Do you wake up at night because of your pain? Yes No
5. What makes your pain better?
 lying down sitting walking bending
Other: _____
6. What makes your pain worse?
 lying down sitting walking bending
7. Are you currently working?
 yes no, due to pain retired disabled

Past Treatment History:

8. Have you ever had back or neck pain before?
 yes no If so, When? _____
9. Have you had back or neck surgery?
 yes no If so, When? _____
10. What diagnostic tests have you had?
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11. Did you have the following treatments for your pain?
Injections: yes no
Did they help? yes no
Physical Therapy: yes no
Did it help? yes no
What did it consist of? _____

12. Rate your pain on a scale of 1 to 10, with 1 being no pain and 10 the most severe pain. Please use an X



Mark these drawings according to where you hurt.

