

PAIN ASSESSMENT FORM



PATIENT NAME: _____

DATE: _____

1. HISTORY OF PAIN / SYMPTOMS

Check the following 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: _____

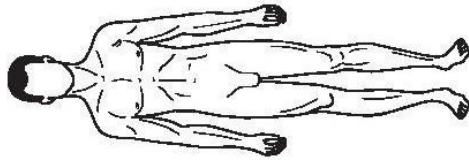
10. MEDICATIONS

Have you been taking any medications for your pain? _____

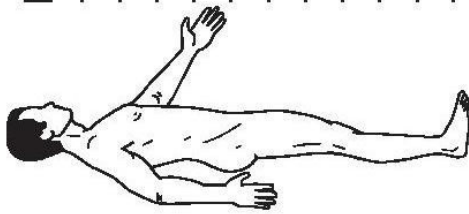
Have you taken medication today: No Yes - What Medication? _____

11. ANY ADDITIONAL INFORMATION YOU FEEL IS IMPORTANT?

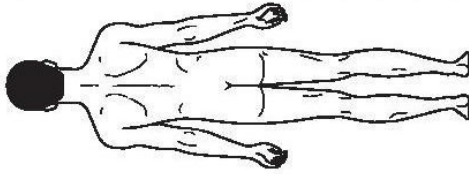
1. PLACE AN X at the location of your pain.



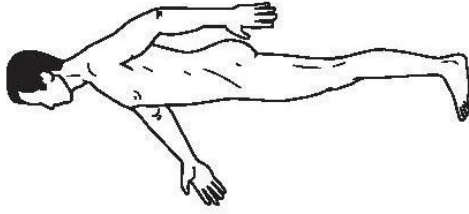
LEVEL	TYPE
10	Aching
9	Burning
8	Constant
7	Dull
6	Numbness
5	Sharp
4	Shooting
3	Stabbing
2	Tender
1	Throbbing
0	Tingling



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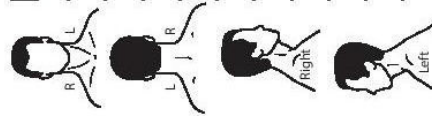


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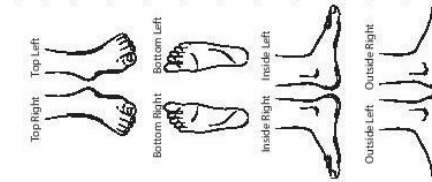
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2. CIRCLE THE LEVEL of pain you experience.



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