

Patient Name(Print) _____ Date _____

Patient ID # _____

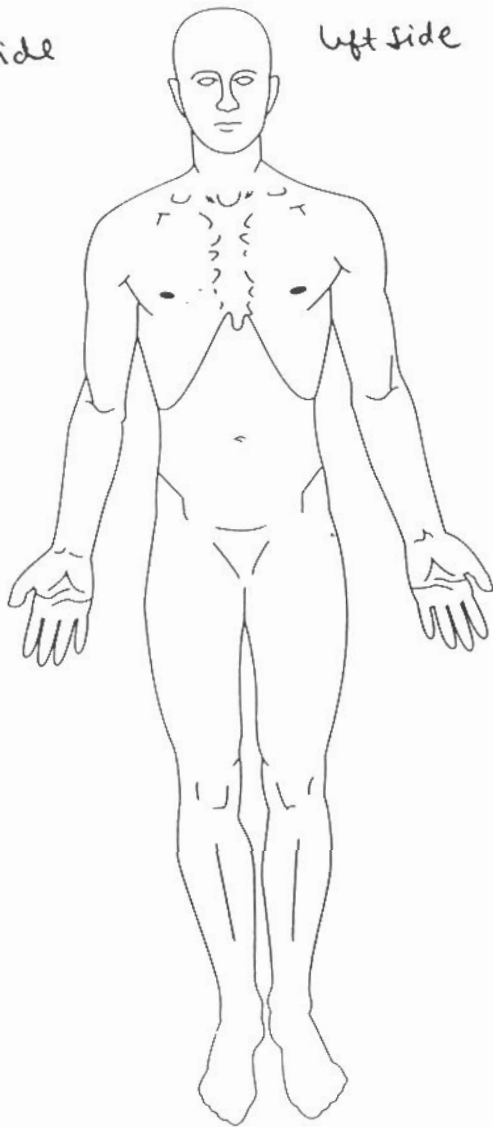
Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb

S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping

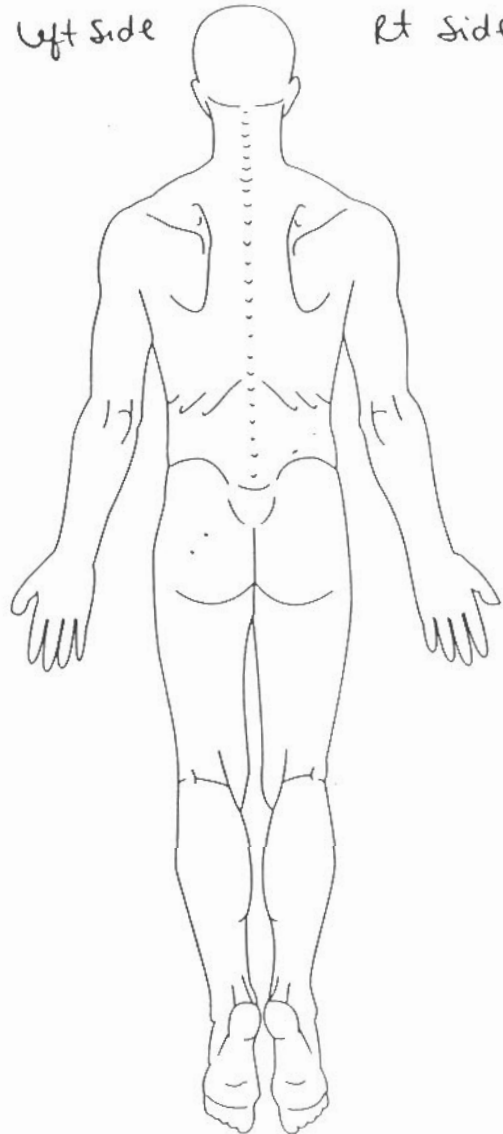
Rt side

Left side



Left side

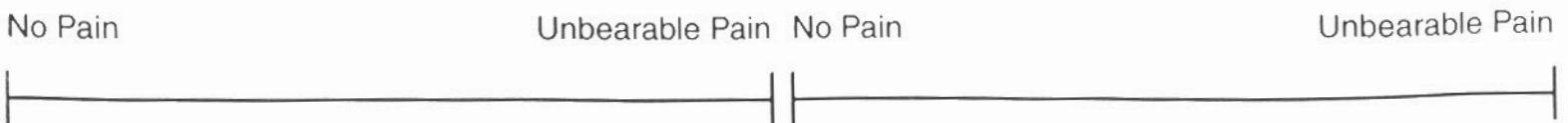
Rt side



On the scales below, please draw a vertical line representing your pain or discomfort:

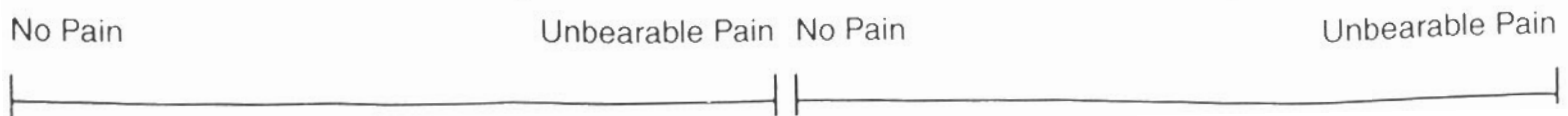
Rate the pain you have right **now**:

Rate your pain at its **best** in the past week:



Rate your **average** pain in the past week:

Rate your **worst** pain in the past week:



Location:

1. One location of your symptom is:
2. Describe your symptoms in this location: _____

- *If pain, please describe if pain is: sharp, dull, burning, stabbing, aching, tingling, other _____
3. Are your symptoms: Constant Frequent Intermittent Occasional Other _____
4. When and how did these symptoms begin? _____

5. How long does it last? _____
6. How did these symptoms occur? Spontaneous Trauma _____ Other _____
7. Have you ever had the same or similar condition? _____ If so, when? _____
8. Has the condition become worse recently? _____ If so, when? _____
9. What makes the problem worse? Exercise Laying Sitting Standing Walking Other _____
10. Is there anything you can do alleviate the symptoms? Cold Heat Laying Meds Rest Other _____
11. Any treatments you have tried and gotten no response? Heat/Cold Muscle Relaxants
Pain Relievers Exercise Surgery Other _____
12. Do you have any associated symptoms? Bladder retention Bowel Constipation Cramps
Tremors Unsteadiness Headaches Dizziness Blurred Vision
13. Are you noticing any leg pain, arm pain, numbness, tingling, or loss of coordination or strength?
