



Pain Assessment Sheet

I feel my pain is (circle all that apply):

- | | | | | | |
|----------|----------|--------------|-----------|------------|-----------|
| Sharp | Burning | Tingling | Tearing | Dull | Cramping |
| Weakness | Aching | Mild | Stiffness | Discomfort | Tightness |
| Severe | Numbness | Other: _____ | | | |

Use the scale below to rate your pain (please circle):

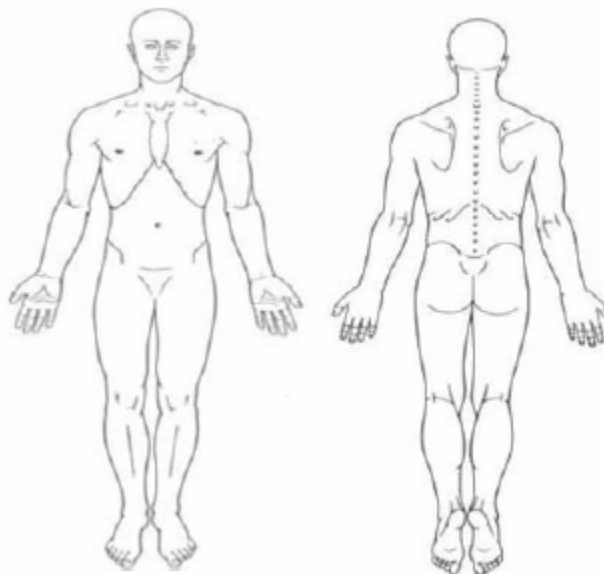
0 1 2 3 4 5 6 7 8 9 10
 None _____ Intolerable

Type of pain you are rating: _____

My pain is:	Better	Worse	No Change
In the morning	_____	_____	_____
Bending forward	_____	_____	_____
Sitting in the car	_____	_____	_____
During mid-day	_____	_____	_____
Lying on my stomach	_____	_____	_____
Coughing/sneezing	_____	_____	_____
Prolonged sitting	_____	_____	_____
Prolonged standing	_____	_____	_____
Prolonged walking	_____	_____	_____

Please indicate areas of pain on the model below:

Mark areas with the following: (Numbness = Lines _____) (Burning = Dashes ----) and (Pain = xxxxx's)





Medical History

Check all conditions that apply to you.

- | | | |
|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Irreg. heartbeat | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Gastric Reflux |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Seizures | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Pass Out |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Unusual Bleeding | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Chron's Disease |
| <input type="checkbox"/> Gallstones | | |
| <input type="checkbox"/> Cancer type: _____ with _____ Chemotherapy _____ Radiation _____ | | |

Did you have surgical treatment and what type:

Please list all medications you currently are taking with dosages and frequency taken:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications allergies: Y__ N__ If yes, list of allergies: _____

Prior surgeries: Y__ N__ If so, date: _____

Do you smoke? Y__ N__ If yes, packs per day? _____ Number of years? _____

Do you drink alcohol? Y__ N__ Beer _____ Wine _____ Liquor _____ # times per week _____

Do you use recreational drugs? Y__ N__ Do you live alone? Y__ N__

Which is your dominant hand? Right _____ Left _____ Both _____

Height: _____ Weight: _____