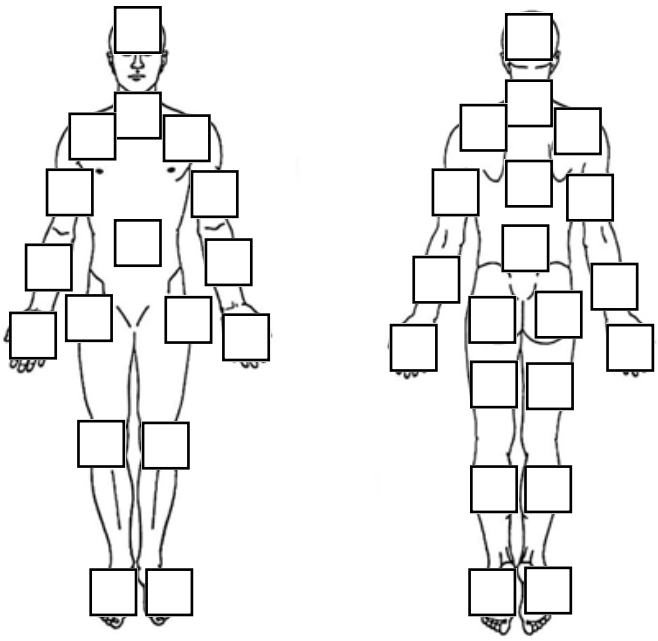
PAIN ASSESSMENT FORM

Advanced Pain Modalities

How long have you had this pain?		Average Pain Level (1 (no pain) to 10 (worst)) 0

On the diagram below, mark the area where you have pain.



Describe the pain

☐ Aching	☐ Mild	☐ Moderate
☐ Burning	☐ Throbbing	☐ Severe
☐ Pins/needles	☐ Constant	☐ Sharp/stabbing
☐ Numbess	☐ Intermittent	

What makes your pain Worse:

What makes your pain Better:

Do you have WEAKNESS in your : ☐ Arms ☐ R ☐ L ☐ Legs ☐ R ☐ L

Do you have NUMBNESS in your : ☐ Arms ☐ R ☐ L ☐ Legs ☐ R ☐ L

TREATMENT HISTORY

For your current symptoms, please mark the boxes for the following imaging/studies that have been performed

☐ X-Ray ☐ MRI ☐ CT scan ☐ Discogram ☐ EMG/NCV (nerve test) ☐ CT myelogram

Where was this imaging/study done?

SELECT

Please mark the type of treatment(s) that you have had in the past and how well they worked, OTHERWISE LEAVE BLANK:

Injections: ☐ Better ☐ Worse ☐ No Change
Type:

Spine Surgery: ☐ Better ☐ Worse ☐ No Change
Type of surgery and year?

TENS unit: ☐ Better ☐ Worse ☐ No Change
Chiropractor: ☐ Better ☐ Worse ☐ No Change
Massage: ☐ Better ☐ Worse ☐ No Change

Physical Therapy: ☐ Better ☐ Worse ☐ No Change
How recently?

Bracing: ☐ Better ☐ Worse ☐ No Change
Type:

Heat / Ice: ☐ Better ☐ Worse ☐ No Change
Acupuncture: ☐ Better ☐ Worse ☐ No Change
Psychology: ☐ Better ☐ Worse ☐ No Change