

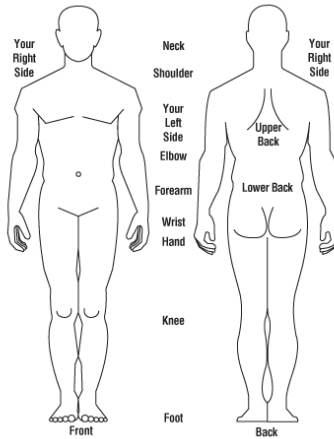
Name: _____

Date: _____

Please mark the area of injury or discomfort on the chart below, utilizing the appropriate symbols:

Pins & Needles: 0000 Burning: XXXX Stabbing: ////

Shooting: **** Aching: ZZZZ



OFFICE USE ONLY

HT: _____

WT: _____

TE: _____

BP: _____

HR: _____

0=NO PAIN

10=EXTREMELY INTENSE PAIN

Pain right now: 0 1 2 3 4 5 6 7 8 9 10
 Worst pain: 0 1 2 3 4 5 6 7 8 9 10
 Best pain: 0 1 2 3 4 5 6 7 8 9 10

Present symptoms: I would describe my pain as:

___ Ache ___ Stiffness ___ Sharp ___ Numbness/Tingling ___ Spasms
 ___ Soreness ___ Shooting ___ Stabbing ___ Burning ___ Other

My pain occurs:

___ Intermittently (comes and goes) ___ Other ___ Once per week
 ___ Constantly (never goes away) ___ Once per day ___ Once per month

My pain is better with:

___ Rest ___ Medication ___ Exercise ___ Change in position ___ Heat ___ Ice
 ___ Standing ___ Walking ___ Sitting ___ Other

My pain is worse with:

___ Lifting ___ Bending ___ Standing ___ Walking ___ Climbing stairs ___ Worry/stress
 ___ Sitting ___ Coughing/Sneezing ___ Sexual intercourse ___ Other

PLEASE UPDATE ANY CHANGES IN YOUR HISTORY SINCE PRIOR VISIT (such as medications, medical conditions, etc):
