

# PAIN ASSESSMENT FORM

Patient Name: \_\_\_\_\_

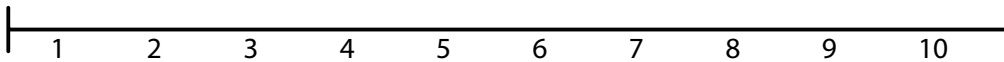
**History of Pain Symptoms:** Date: \_\_\_\_\_

1. Please check the following symptoms that you have  
 back pain     leg pain     tingling/numbness in leg  
 neck pain     arm pain     tingling/numbness in arm
2. When did your symptoms begin: \_\_\_\_\_
3. Are you experiencing any problems controlling your bladder or bowels?  
Bowel:  Yes     No  
Bladder:  Yes     No
4. Do you wake up at night because of your pain?  Yes     No
5. What makes your pain better  
 lying down     sitting     walking     bending  
Other: \_\_\_\_\_
6. What makes your pain worse  
 lying down     sitting     walking     bending
7. Are you currently working?  
 yes     no, due to pain     retired     disabled

**Past Treatment History:**

8. Have you ever had back or neck pain before?  
 yes     no If so, When? \_\_\_\_\_
9. Have you had back or neck surgery?  
 yes     no If so, When? \_\_\_\_\_
10. What diagnostic tests have you had? \_\_\_\_\_
11. Did you have the following treatments for your pain?  
Injections:  yes     no  
Did they help?  yes     no  
Physical Therapy:  yes     no  
Did it help?  yes     no  
What did it consist of? \_\_\_\_\_

12. Rate your pain on a scale of 1 to 10, with 1 being no pain and 10 the most severe pain. Please use an X



Mark these drawings according to where you hurt.

