PAIN ASSESSMENT FORM

Patient Name: _____

History of Pain Symptoms: Date:_____

1. Please check the following symptoms that you hav
   ☐ back pain ☐ leg pain ☐ tingling/numbness in le
   ☐ neck pain ☐ arm pain ☐ tingling/numbness in arı
2. When did your symptoms begin?_____
   _____
3. Are you experiencing any problems controlling your bladder or bowe
   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 usn X

1 2 3 4 5 6 7 8 9 10

Mark these drawings according to where you hurt.