PAIN ASSESSMENT

PATIENT NAME: _____ **DATE:** _____

1. **HISTORY OF PAIN / SYMPTOMS**
   Check the folowing symptoms that you have:
   - ☐ Back Pain
   - ☐ Neck Pain
   - ☐ Leg Pain
   - ☐ Tingling/Numbness in Leg
   - ☐ Arm Pain
   - ☐ Tingling/Numbness in Arm
   - ☐ Other

2. **WHEN DID SYMPTOMS BEGIN?** _____

3. **HAVE YOU EVER HAD THIS PAIN BEFORE?**
   ☐ No ☐ Yes - When? _____

4. **WHAT DIAGNOSTIC TESTS HAVE YOU HAD** (MRI, X-Ray, CT Scan, Etc.) **?**
   _____

5. **HAVE YOU EVER HAD SURGERY FOR THIS ISSUE?**
   ☐ No ☐ Yes - What and When? _____

6. **HAVE YOU HAD ANY OF THE FOLLOWING TREATMENTS FOR YOUR PAIN?**
   Injections: ☐ No ☐ Yes - Did it help? _____
   Physical Therapy: ☐ No ☐ Yes - Did it help? _____
   What type of Therapy? _____

7. **WHAT MAKES YOUR PAIN BETTER?** _____

8. **WHAT MAKES YOUR PAIN WORSE?** _____

9. **DOES YOUR PAIN AFFECT ANY OF THE FOLLOWING?**
   - ☐ Movement
   - ☐ Sleep/Rest
   - ☐ Emotions
   - ☐ Activities - Explain: _____
   - ☐ Relationships
   - ☐ Concentration
   - ☐ Bowels
   - ☐ Bladder
   - ☐ Other - Explain: _____

10. **MEDICATIONS**
    Have you been taking any medications for your pain? _____
    _____
    Have you taken medication today: ☐ No ☐ Yes - What Medication? _____
    _____

11. **ANY ADDITIONAL INFORMATION YOU FEEL IS IMPORTANT?**
    _____
    _____