



# PATIENT PAIN FORM

Onset date \_\_\_\_\_

*Please mark on this line the level or intensity of pain that you are presently experiencing over all from zero to 10:*

\_\_\_\_\_ Absent Severe 10

### Neck-shoulder-arm-Pain

\_\_\_\_\_ Absent Severe 10

### Mid Back Pain

\_\_\_\_\_ Absent Severe 10

### Low Back and Leg Pain

\_\_\_\_\_ Absent Severe 10

Pain frequency:  Constant  Frequent  Intermittent  Occasional

Aggravated by:  Sitting  Standing  Lying  Walking  
 Bending  Coughing  Other

Have you ever experienced this complaint before?  Yes  No

If yes please explain:

\_\_\_\_\_  
 \_\_\_\_\_

If yes what has been done to correct the complaint?

\_\_\_\_\_  
 \_\_\_\_\_

Another doctor involved? \_\_\_\_\_ who? \_\_\_\_\_

Has anyone in your family ever suffered from the same complaint?

Yes  No who? \_\_\_\_\_

What activities does this pain keep you from doing?

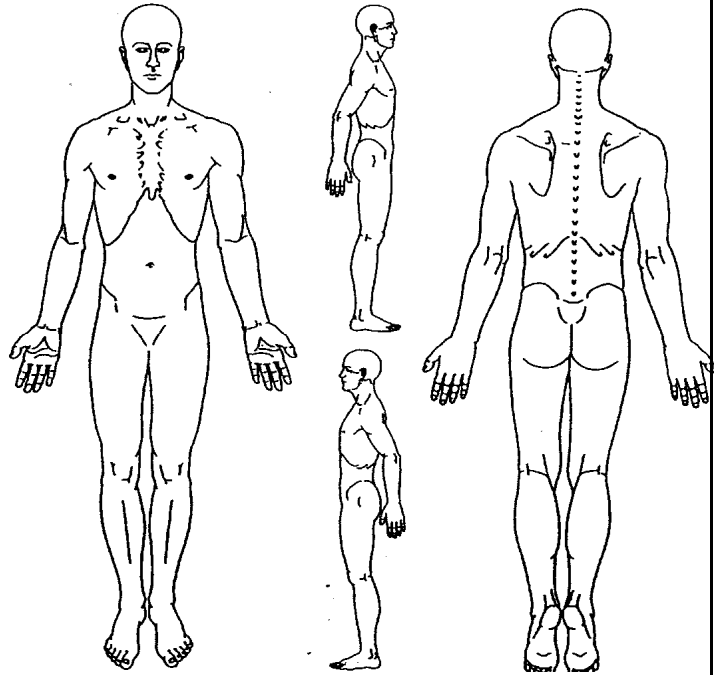
\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Does this pain keep you from doing normal daily activities?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*Mark the areas on the body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas.*

NNN = Numbness AAA = Ache BBB = Burning SSS = Stabbing  
 PPP = Pins & Needles OOO= Other



For re-exams only:

Has there been any changes in current complaint?

Yes  No if yes explain \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Do you have any new complaints to report?  Yes  No

If yes, \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Please Print Name: \_\_\_\_\_ Filled out by: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_