



(Please Print Clearly) **Patient Pain History**

Name _____ DOB _____ Age _____ Date _____

Pain level today: 0 1 2 3 4 5 6 7 8 9 10

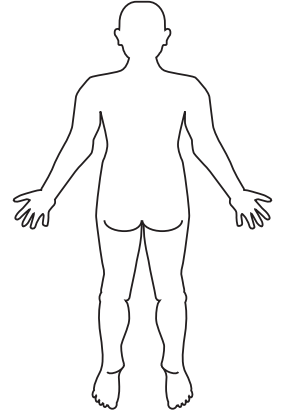
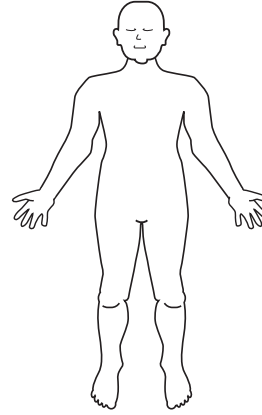
Previous back surgery? Yes No

Would you describe your pain as: Constant Intermittent

Does your pain disrupt your sleep? Yes No

Where do you have pain? (indicate on the diagram at right)

How and when did your pain begin?



Indicate the location of your PAIN in black and NUMBNESS in RED on the diagram

What is the intensity of your pain? Burning Stabbing Pressure Electric Sharp Dull Aching Throbbing
Gnawing Shooting Numbness Tingling Other _____

What makes your pain worst? _____

What makes your pain better? _____

Can you walk? Yes No

Do you use an assistive device? Cane Walker Wheelchair Scooter Crutches None Other _____

What activities are you prevented from doing? _____

Please list all previously or currently used methods of pain management:

Acupuncture Massage Chiropractor Facet Block Trigger Point Injection Exercise Physical Therapy
Epidural Injection Nerve Block Hypnosis Nerve Destruction Medication Acupressure Meditation
Peripheral Nerve Block Other _____

Have you ever had an MRI done? Yes No

If yes, when and where? _____

Do you work? Yes No Retired

If yes, please describe job activities _____

Current Pharmacy _____ Phone No. _____

Patient Signature

Date

Reviewed by: