PAIN ASSESSMENT

Patient Name_____Date_____

Chief Complaint 1._____2._____

Is your present problem due to injury

☐ On the job? ☐ Auto Accident? ☐ Personal Injury? ☐ Other_____

Did you pain begin ☐ Gradually? ☐ Suddenly?

Is you pain worse when you

☐ Sit ☐ Bend ☐ Walk ☐ Lift ☐ Push ☐ Pull ☐ Other_____

Which of the following areas do you have the most pain, discomfort or restriction of motion?

☐ Neck ☐ Shoulders ☐ Arms ☐ Hands ☐ Upper Back ☐ Mid Back ☐ Low Back

☐ Pelvis ☐ Hips ☐ Legs ☐ Knees ☐ Feet ☐ Other_____

On an 8 hour day rate the % your pain when you:

Sit:_____% of the time

Stand:_____% of the time

Walk:_____% of the time

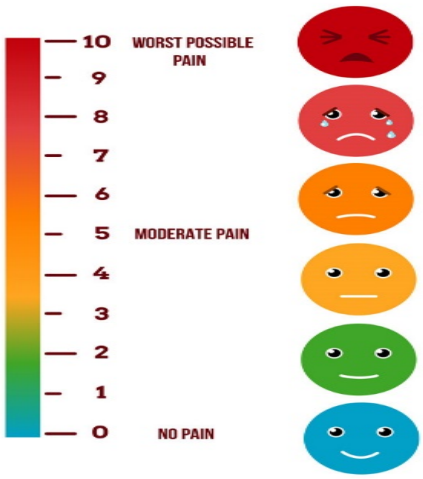
(Occasionally = 33%; Frequently = 34-68%; Continuously = 67-100%)

What percent of the time are you:

Housebound:_____ % of the time

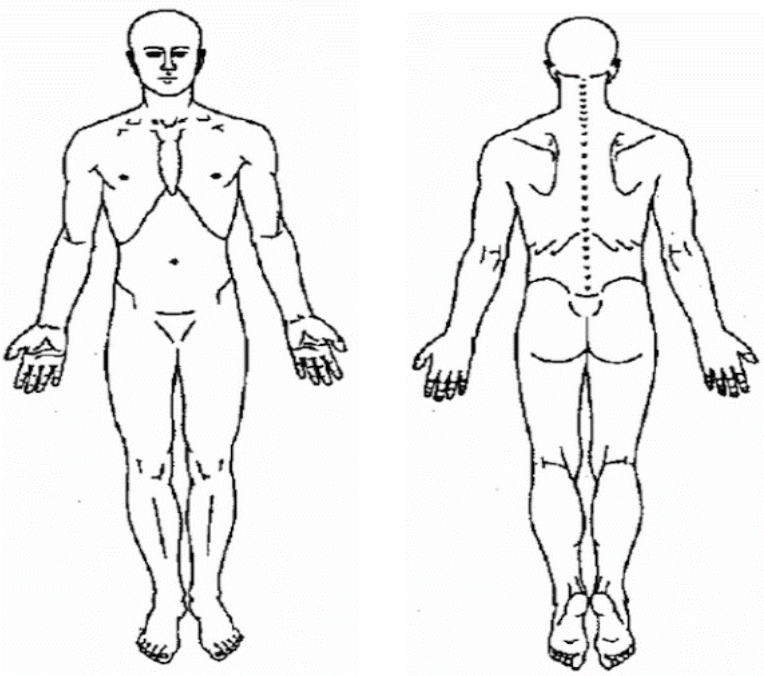
Chair bound:_____% of the time

Bedfast: _____% of the time



Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



Does your pain interfere with your Work? Sleep? Daily Routine?

List any additional comments you wish to make regarding your condition _____

_____

_____

Patient Signature _____