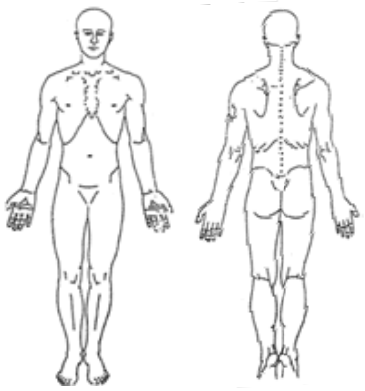
NAME: DATE OF BIRTH:

Using the appropriate symbols, mark on the body diagram where you feel the following sensations:

Numbness	Pins & Needles	Burning	Stabbing	Aching
===	ooo	xxx	///	***



Please mark (with an x) on the line below indicating how bad your pain is now:

NO PAIN ----------WORST POSSIBLE PAIN

1. What activities make your pain worse? Please check ALL that apply to you.

☐ Lying ☐ Standing ☐ Exercise (during) ☐ Bending Forward ☐ Twisting
☐ Sitting ☐ Walking ☐ Exercise (after) ☐ Bending Backward ☐ Coughing/Sneezing

2. What reduces your pain? Please check ALL that apply to you.

☐ Lying ☐ Standing ☐ Exercise (during) ☐ Bending Forward ☐ Twisting
☐ Sitting ☐ Walking ☐ Exercise (after) ☐ Bending Backward ☐ Coughing/Sneezing

3. What medication and dosage either prescriptions or over the counter are you currently taking for this pain?

_____

_____

☐ NONE

4. Are you currently under treatment at a Pain Center?

☐ No ☐ Yes, if so where: _____

5. Are you currently inder a pain contract with anyone?

☐ No ☐ Yes, if so where and length of time: _____

6. What treatments have you tried for this pain?

☐ Physical Therapy ☐ Chiropractic ☐ Acupuncture ☐ Home Exercises ☐ NONE

7. Have you been seen for this current pain by :

☐ MD/NP/PA _____ ☐ Emergency Room Date:_____
☐ Urgent Care Center Date:_____ ☐ Hospitalized Date:_____
☐ NONE ☐

8. Have you had any of the following tests?

☐ XRAY Date:_____ ☐ MRI Date:_____
☐ CT Scan Date:_____ ☐ EMG/NCS Date:_____
☐ Other
☐ NONE