

# PAIN ASSESSMENT FORM

Patient Name \_\_\_\_\_

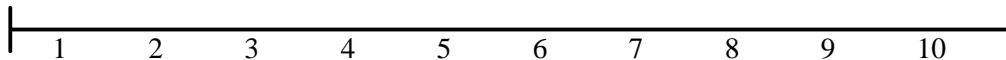
## History of Spine Symptoms:

- Please check the following symptoms that you have:  
 back pain     leg pain     tingling/numbness in leg  
 neck pain     arm pain     tingling/numbness in arm
- When did your symptoms begin? \_\_\_\_\_
- Are you experiencing any problems controlling your bladder or bowel?  
Bowel:  Yes     No  
Bladder:  Yes     No
- Do you wake up at night because of your pain?     Yes                       No
- What makes your pain better?  
 lying down               sitting               walking               bending  
Other: \_\_\_\_\_
- What makes your pain worse?  
 lying down               sitting               walking               bending
- Are you currently working?  
 yes               no, due to pain     retired               disabled

## Past Spine Treatment History:

- Have you ever had back or neck pain before?  
 yes               no If so, When? \_\_\_\_\_
- Have you had back or neck surgery?  
 yes               no
- What diagnostic tests have you had?  
 CT Scan     MRI     X-Ray     EMG/NCS
- Did you have the following treatments for your pain?  
Injections:  yes     no  
Did they help?  yes     no  
Physical Therapy:  yes               no  
Did it help?  yes     no  
What did it consist of? \_\_\_\_\_

- Rate your pain on a scale of 1 to 10, with 1 being no pain and 10 the most severe pain. Please use an X



Mark these drawings according to where you hurt. Please use the scale below to indicate which sensations you are feeling.

/// Stabbing

XXX Burning

+++ Aching

=== Numbness

000 Pins & Needles

