

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Where is your pain?

Mark the area on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas.

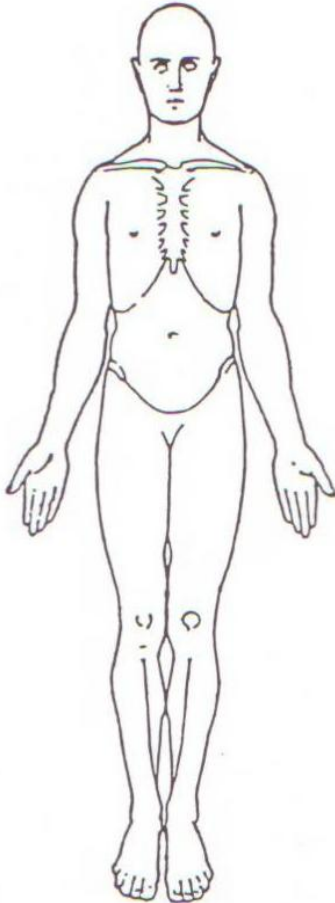
Aching  
▲▲▲

Numbness  
=====

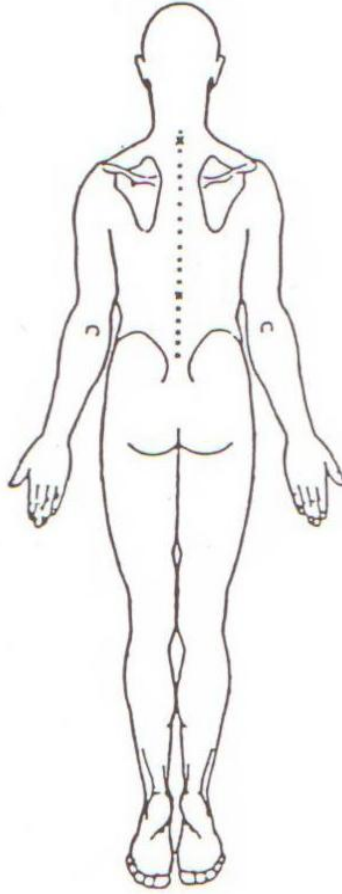
Pins and Needles  
○○○○

Burning  
XXX

Stabbing  
/////



Right Left  
Front



Left Right  
Back



Right  
Side



Left  
Side

How bad is the pain?

Please mark an **X** on the body form where the pain is the worst now.

Please circle how bad the pain is on a scale of 1 to 10, 10 being the worst. **1 2 3 4 5 6 7 8 9 10**

When (roughly what Date) did your present Pain start? \_\_\_\_\_

How long have you had this pain? \_\_\_\_\_

How long have you had similar pain? \_\_\_\_\_

How did the pain start? (check the appropriate box)

- Suddenly
- Gradually
- Lifting
- Twisting
- Fall
- Injured at work
- Injured in an Auto accident
- Hit from behind
- Injured during sports
- No apparent cause

What activities make the pain worse? (check the appropriate box)

- Exercise
- Sitting
- Standing
- Walking
- Bending
- Coughing

What reduces the pain? (check the appropriate box)

- Lying down
- Sitting
- Standing
- Exercises in physical therapy
- Pain Medicine
- Nothing
- Other \_\_\_\_\_