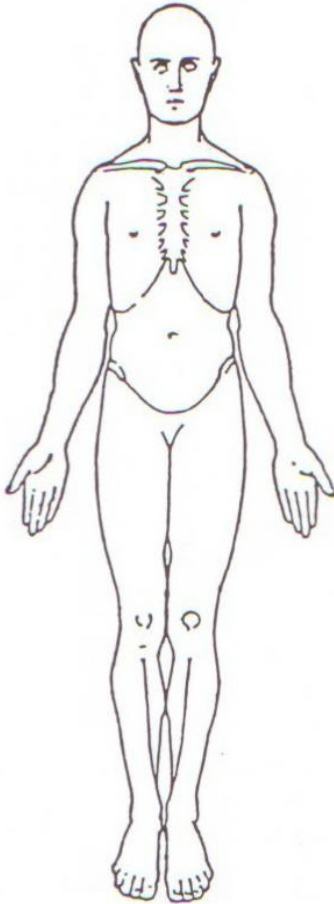
Name:____ Date:__________________________________

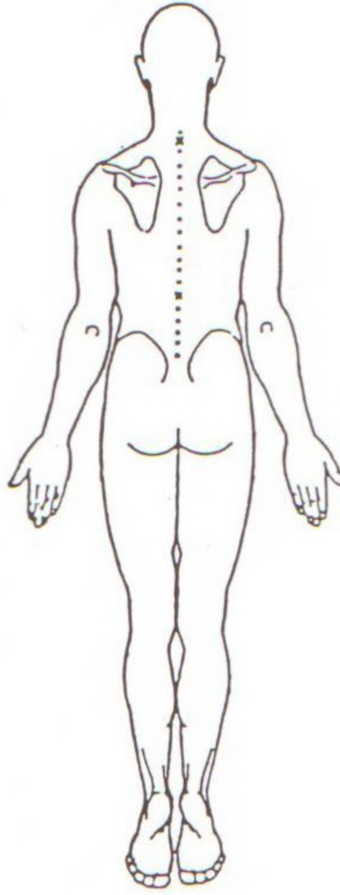
Where is your pain?

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	Stabbing
▲▲▲	= = = = =	○ ○ ○ ○	X X X	/ / / / / /



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 _________________