

DOCTOR \_\_\_\_\_

DATE OF VISIT \_\_\_/\_\_\_/20\_\_\_ Patient \_\_\_\_\_ Age \_\_\_\_\_

Check ONE: \_\_\_\_\_ INITIAL EXAMINATION \_\_\_\_\_ RE-EVALUATION \_\_\_\_\_ NEW CONDITION

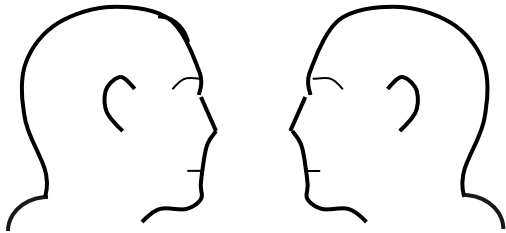
FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms \_\_\_\_\_

FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? \_\_\_\_\_

**SUBJECTIVE PAIN ASSESSMENT**

**Right**

**Left**

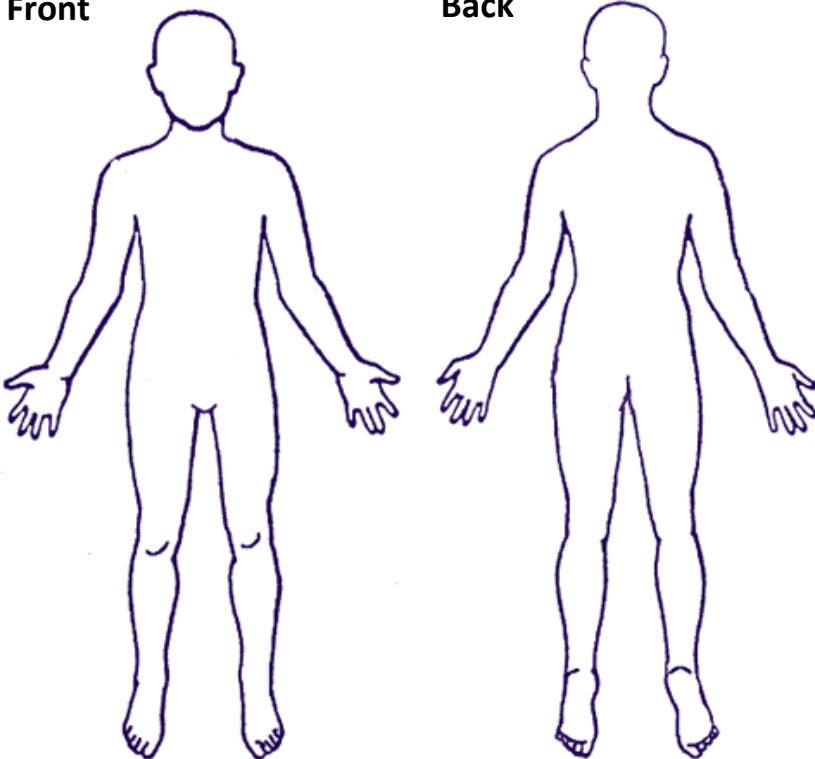


**RATE YOUR PAIN**

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

**Front**

**Back**



- A=Ache
- B=Burning
- ST=Stabbing
- SP=Spasm
- N=Numbness
- P=Pins and Needles
- T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

**PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE**

**DATE**

\_\_\_\_\_

\_\_\_\_\_