PAIN EVALUATION

Where is your Pain? (Please mark all painful areas on the diagram below with an X. No circles, arrows or shading please)

When did this (latest episode) start? Describe your symptoms ____________________________
____
____
____

What do you think happened to cause it?____
____
____

Intensity: (how bad is the pain? Circle the appropriate number: 0 = no pain; 10 = worst pain possible)

Now: 0 1 2 3 4 5 6 7 8 9 10

At worst: 0 1 2 3 4 5 6 7 8 9 10

Pain Characteristics:

(Circle all that apply) **Sharp** **Dull** **Burning** **Aching** **Pressure** **Pins and Needles** **Other**

Timing: Constant? YES/ NO Worse? Morning_____ Afternoon______ Evening ____ Night ___________

What makes it better? ____

____

What makes it worse? ____

____

Have you had any previous injuries? Y N *If yes please describe below*:

*Problem*____*Date*________

____

____

*How did the problem resolve (treatment, surgery, went away, etc.)*______________

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*Problem*____*Date*________

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*How did the problem resolve (treatment, surgery, went away etc.)*______________

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*Problem*____*Date*________

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*How did the problem resolve (treatment, surgery, went away, etc.)*______________

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