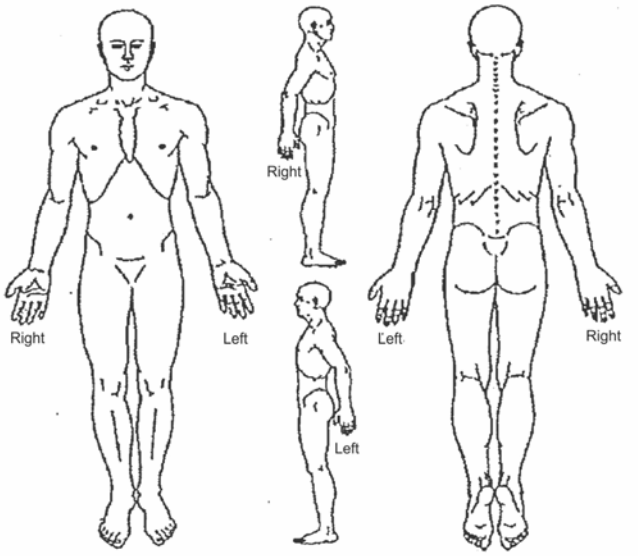
Name: _____ Date of Birth: _____ Date: _____
Interpreter Name/Certification #: _____

Spine & Nerve Diagnostic Center Pain Assessment

Please mark the diagram to the right where you feel pain or sensation using the symbols indicated
Please rate the severity of pain you are currently experiencing on a scale of 0 – 10, with 0 being no pain and 10 being the worst pain imaginable.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - - - -	oooooooooo	^^^^^^^^^^	xxxxxxxxxx	⊗⊗⊗⊗⊗



Pain level without medications
0 1 2 3 4 5 6 7 8 9 10

Pain level with medications
0 1 2 3 4 5 6 7 8 9 10

Have you had any new treatment, imaging, or procedures since your last visit? If so, please list:

Chief Complaint/Reason for Appointment?

What medications are you currently taking/any CHANGES?

What are your allergies?

What are your symptoms since your last visit? (circle all that apply)

Cardiovascular	Chest Pain	Rapid Heartbeat	Leg/Ankle Swelling	Irregular Heartbeat		
Constitutional	Weight Loss/Weight gain	Fever	Chills	Night Sweats	Fatigue	
Eyes	Blurry Vision	Eye Pain	Eye Discharge	Dry Eyes	Decreased Vision	
Gastrointestinal	Nausea/Vomiting	Stool Incontinence	Blood in stool/black stool	Constipation	Heartburn	Diarrhea
Genitourinary	Bladder Incontinence	Urinary Tract Infections	Trouble Urinating			
Musculoskeletal	Joint Pain	Muscle Pain	Joint Swelling	Muscle Weakness	Muscle Spasm	Stiffness
Neurological	Migraines	Numbness	Dizziness	Headaches	Loss of Balance	
Psychological	Depression	Anxiety	Insomnia			
Respiratory	Short of Breath	Cough	Wheezing	Pain with Breathing		
Skin	Rash	Sores	Itching	Easily bruises	Easily scars	

What is your work status? (circle all that apply)
Working full duty Working modified duty Working part-time Not working Retired

What is your job title? _____

What activities make your condition worse? (circle all that apply)
Sitting Standing Walking Bending Lifting Laying down

What activities make your condition better? (circle all that apply)
Sitting Standing Laying down Medications Injections Physical therapy

Circle the following that apply to you. (circle all that apply)
Single Married In a relationship Smoker Non-smoker Drink alcohol rarely Drink alcohol often Never drink alcohol

Compared to your last visit, how is your pain level? (circle one) Better Worse The Same

Who is your primary care physician? _____

Is there any chance you may be pregnant today? (Circle One) YES NO

FOR OFFICE USE ONLY:	Height:	Weight:	Temperature:
Revised 6/18/18	Blood Pressure:	Heart Rate:	

Allergies to iodine? YES NO
Any chance of pregnancy? YES NO
Diabetic? B/S____ YES NO