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**PAIN SCALE**

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Who referred you? \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_  Right Handed

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  Left Handed

**CHIEF COMPLAINT**

What is the reason for your visit today? What is bothering you most? \_\_\_\_\_

How long?  Days  Weeks  Months  Years

Lately, or since my last visit I am  Better  Worse  Same

Pain today |-----|  
None 1 2 3 4 5 6 7 8 9 10 Horrible

Normally I feel |-----|  
Great  Moody  Sad  Depressed Poor

Today I feel |-----|  
Great Poor

My function and quality of life has |-----|  
Improved Declined

Endurance |-----|  
Great Poor

My sleep is |-----|  
Great Poor

**My problem is located (check all that apply)**

- Neck  Right Arm  Shoulder  Right Hip  Right Foot  Right Hand  Thumb
- Low Back  Left Arm  Left  Left  Left  Left  Middle Finger
- Right Leg  Arm  Right Knee  Right Toes  Right  Little Finger
- Left Leg  Left  Left  Left  Left

My pain is:  Dull  Achy  Throbbing  Sharp  Burning  Lancinating

Constant  Numbness  Tingling  Weakness  Stabbing

Improves with:  Rest  Heat  Ice  Therapy  Medications

Made Worse:  Walking  Bending  Sitting  Working  Therapy

Tests Done:  X-rays  Nerve Studies  CT/MRI  Bone Scan

Injury:  None  Auto Accident  Sports  Work Related  Injury (other) \_\_\_\_\_

**Medication:**

**Allergies:**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

No risk to harm myself or others \_\_\_\_\_ (Signature or initial)

What has changed since your last visit?  Not Applicable \_\_\_\_\_