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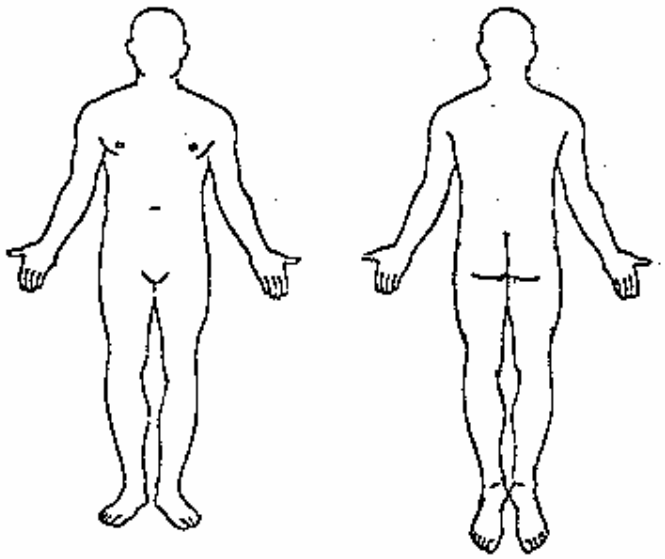
PAIN SELF-EVALUATION

PLEASE FILL OUT THE ENTIRE FORM

NAME:_____ AGE:_____ DATE:_____
REFERRING PHYSICIAN (if any)_____

Describe in your own words, what your pain is like (where it is, how it feels, is it constant, does it come and go, does it radiate to other parts of your body):_____
_____
_____
_____
How long have you had this problem?_____
How did your pain problem first start? (Accident, etc.) Please describe:_____
_____
_____
_____
Have you had any previous treatments for this pain? (Surgeries, other blocks, medications) If so, please list below along with the date.
_____
_____
_____
_____

In the figures below, indicate the following:
1. ***Entire painful areas (xxxxxxxxxx)***
2. ***Single most painful area (*******)***
3. ***Areas of numbness and tingling (ooooooo)***



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Does the pain move from one area to another? (yes/no). If yes describe

_____

_____

With the following, indicate if the pain is increased (I) or decreased (D)

Walking_____ Sitting_____ Standing_____ Reclining_____ Sleeping_____ Fatigue_____ Tension_____ Exercise_____ Sexual Activities_____ Bending_____ Working_____ House Cleaning_____ Alcohol_____ Medication_____ Bowl Movement_____ Lifting_____

When did you last work your regular job (date)?_____

Is your case Workman's Compensation? (yes/no)_____

Are you involved in a lawsuit because of the pain (yes/no)? _____

Additional Comments:_____

_____

_____