

Pain Assessment Sheet

Name		File #		Date	
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Current Complaints	
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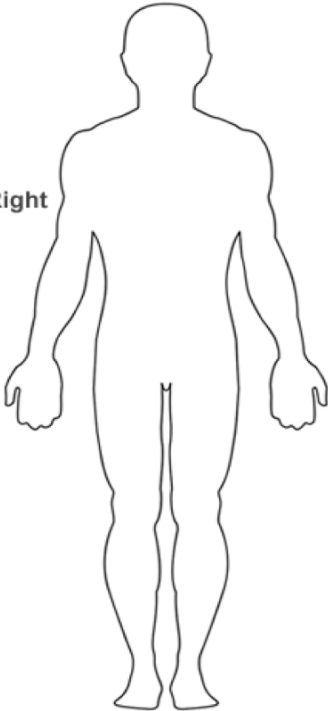
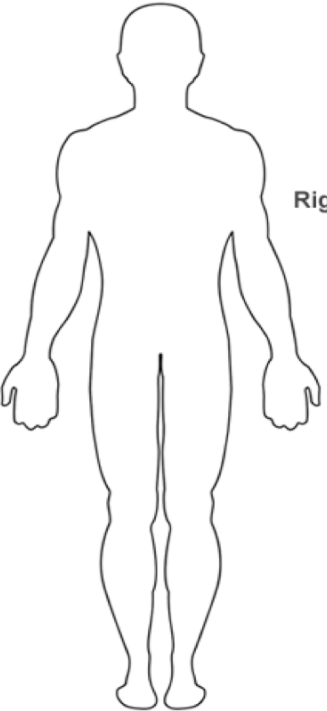
Progression of your current condition since it started	<input type="checkbox"/> Same	<input type="checkbox"/> Improved	<input type="checkbox"/> Worse	<input type="checkbox"/> Other
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Does your present condition affect your daily activities at home or in the office? Describe:

Type of pain

<input type="checkbox"/> Sharp	<input type="checkbox"/> Tingling	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Numbness	<input type="checkbox"/> Aching	<input type="checkbox"/> Shooting	<input type="checkbox"/> Dull
<input type="checkbox"/> Burning	<input type="checkbox"/> Cramping	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Swelling	<input type="checkbox"/> Other _____		

Other comments and notes	
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<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>Front</p>  <p>Right Left</p> </div> <div style="text-align: center;"> <p>Back</p>  <p>Right</p> </div> </div>	<p>Describe the areas where you feel pain and provide as much detail as possible. Mark the body outline to indicate location of pain.</p> <div style="height: 350px;"></div>
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