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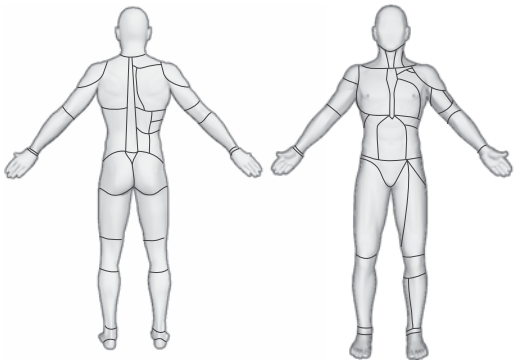
PATIENT ASSESSMENT FORM

My main complaint(s): _____

Please mark the appropiate locations on the diagrams below. Please indicate where the pain goes (radiating pain) with arrows.



Duration of Pain: _____

Nature of Pain ( ) Constant ( ) Intermittent

Quality of Pain

Please mark all that apply:

( ) Throbbing ( ) Cramping ( ) Gnawing ( ) Aching
( ) Shooting ( ) Stabbing ( ) Sharp ( ) Hot-Burning
( ) Heavy ( ) Tender ( ) Splitting ( ) Sickening

Other: _____

Intensity of Pain

On a scale of 0 - 10, with 10 being the worst imaginable pain and 0 the absence of pain, how would you rate your pain?

At Worst	0	1	2	3	4	5	6	7	8	9	10
At Best	0	1	2	3	4	5	6	7	8	9	10
Average	0	1	2	3	4	5	6	7	8	9	10

What makes your pain worse?

( ) Bending ( ) Lifting ( ) Coughing ( ) Sneezing
( ) Defecation ( ) Sexual Intercourse ( ) Prolonged Sitting
( ) Prolonged Standing ( ) Walking

In what time period is your pain the worst?

( ) Early Morning ( ) Late Evening

What makes your pain better?

( ) Rest ( ) Activity/Physical Therapy ( ) Massage ( ) Heat
( ) Cold ( ) Lying in a fetal position ( ) Lying on your back
( ) Medication: _____