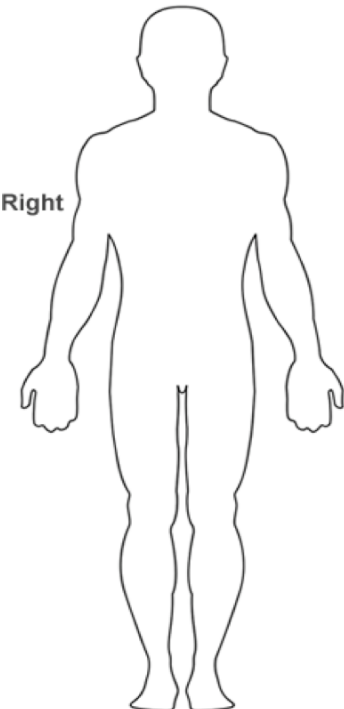
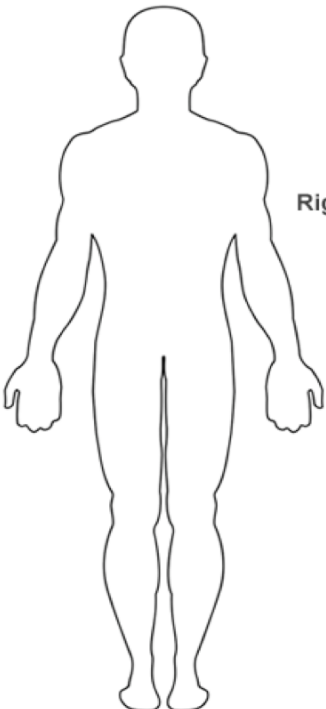


Pain Assessment Sheet

Name		File #		Date	
Current Complaints					
Progression of your current condition since it started		<input type="checkbox"/> Same	<input type="checkbox"/> Improved	<input type="checkbox"/> Worse	<input type="checkbox"/> Other
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"/> Burning	<input type="checkbox"/> Cramping	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Swelling	<input type="checkbox"/> Other _____	
Other comments and notes					
<div><div><p>Front</p><p>Right</p><p>Left</p></div><div><p>Back</p><p>Right</p><p>Left</p></div></div>				Describe the areas where you feel pain and provide as much detail as possible. Mark the body outline to indicate location of pain.	