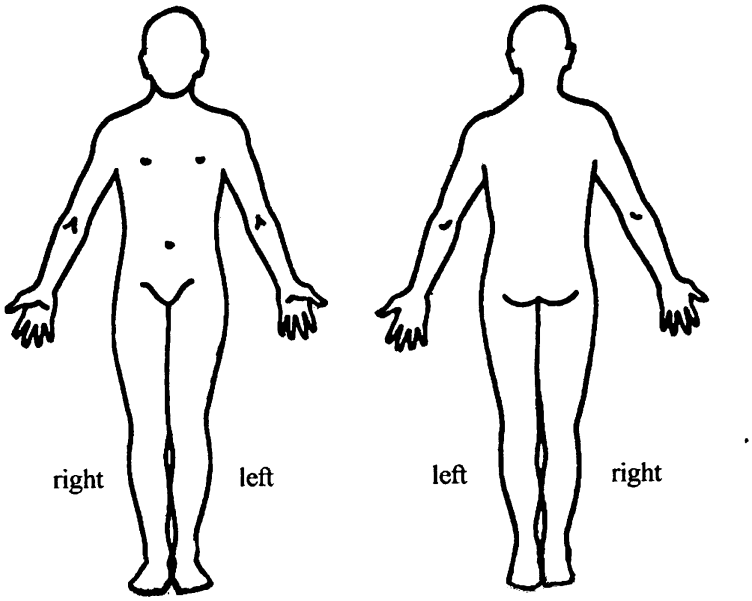
PATIENT PAIN FORM

Mark the area on the body shown below where you feel the described sensations. Use the appropriate symbols. Mark all areas of radiation. Include all affected areas.



Numbness **. . . . . .**

Pins and Needles **OOOOOO**

Burning **XXXXXX**

Aching **********

Stabbing //////////////

Visual Analog Scale
The line below represents the intensity of low back pain. Please mark an '**X**' at the position on the scale which indicates how much pain you feel at this time.

Low back pain: I----------I

Other area: I----------I

_____

Is the described pain: Constant □ Occasional □

Does it wake you out of a sound sleep? Yes □ No □

Does it interfere with your:
Work □ Sleep □ Daily Routine □ Recreation □

Please indicate when you get the most pain. Check one only.
Sit □ Walk □ Stand □ Bend □ Lying Down □ Other □

Patient Signature: _____Date:_____