

Medical History

List medications you are currently taking: _____

List any medical conditions: _____

List any surgeries: _____

Pain History

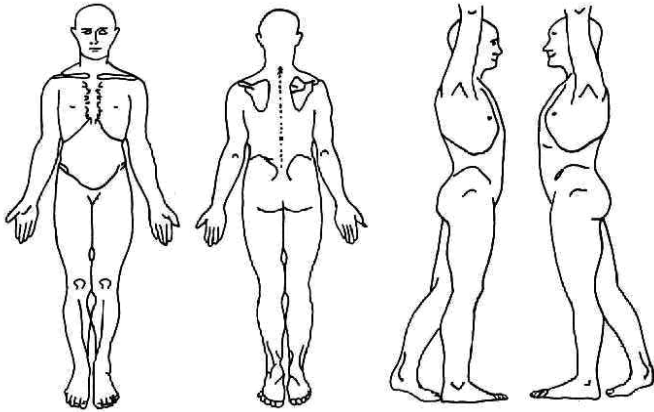
When did your symptoms begin: _____

Previous treatments for symptoms: _____

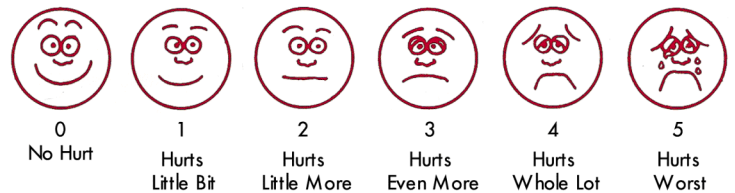
What makes your pain better: _____

What makes your pain worse: _____

Use the body chart below to mark or shade the area where your pain is located.



Please use the scale below to indicate your level of pain with 0 being no pain and 10 being the most pain



Circle the type of pain you are having. You can circle more than one.

Throbbing Shooting Stabbing Sharp Cramping Gnawing

Hot-burning Aching Heavy Tender Splitting Tiring

Sickening Fearful Punishing-Cruel

Other _____