PLEASE DESCRIBE YOUR PAIN

NAME: _____ ***DATE***: _____

When and how did this begin? _____

Is this the first time you've had this pain? _____ ***If no, when was the last incident?*** _____

How often do you feel the pain? Constant Frequent Intermittent Varies

Your pain intensity? Mild Mild to moderate Moderate Moderate to severe Severe

How would you describe your movement? Inflexible Restricted movement Stiffness

If any, what sensations are you feeling? Crawling Dead Numb Pins and needles Prickly Tingling

What does the pain feel like? Achey Burning Dull Excruciating Pounding Pulsating Sharp Shooting Stabbing Stinging Throbbing

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PLEASE CIRCLE WHAT MAKES YOUR PAIN WORSE

Coughing Sneezing Straining at bowel movements Emotional upset Flashing lights Movement of the head Reclining Driving Exercising Getting out of bed Sleeping Stress Carrying things Arising from a chair Bending Climbing stairs Lifting Pulling things Pushing things Sitting Standing Stooping Walking Raising your arm Rotating the arm inward Rotating the arm outward Reaching Repetitious movements

Other _____

PLEASE CIRCLE WHAT MAKES YOUR PAIN LESS

Taking medication Exercising Reclining Resting Sitting Sleeping Walking Applying ice Applying heat Massaging by hand Tub soaking Movement Other _____

CIRCLE YOUR PAIN RATING: (least) 1 2 3 4 5 6 7 8 9 10 (most)