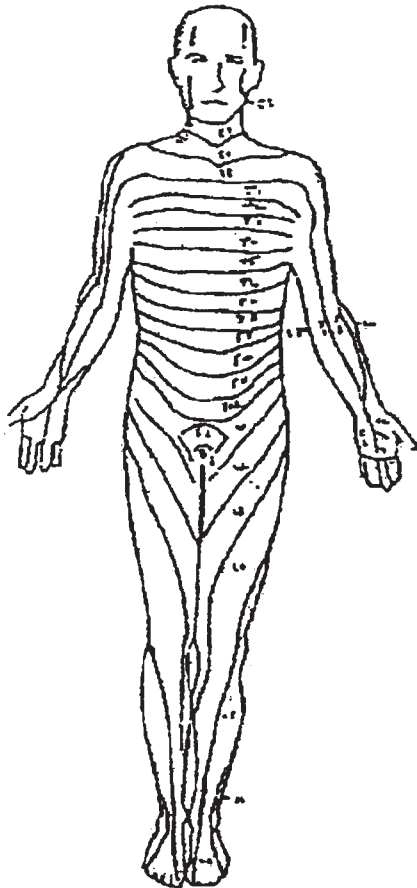


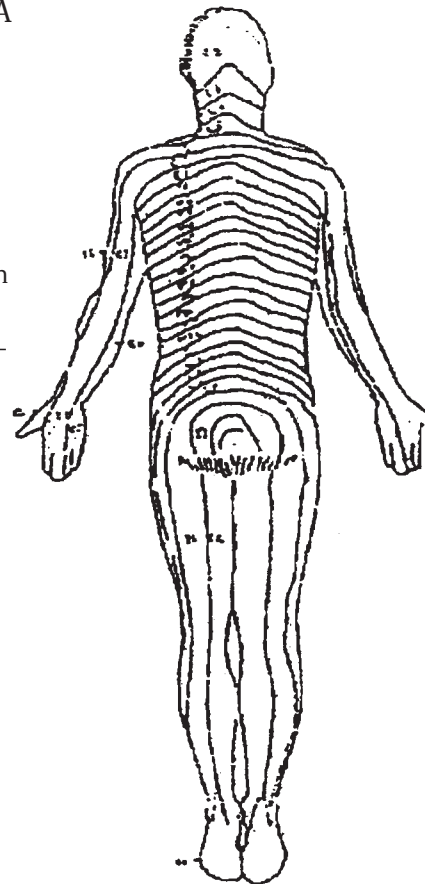
TO BE COMPLETED BY PATIENT

NAME _____ DATE _____

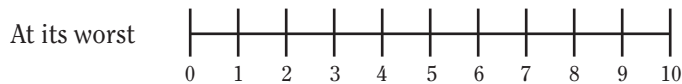
PAIN LOCATION -- SHADE IN PAINFUL AREA
WHICH WORDS DESCRIBE YOUR PROBLEM
PLEASE CHECK (✓)



- Ache Burning Hot
- Pins / Needles Stabbing Cold
- Numbness Pressure Vibration
- Other _____



On a Scale of 0 (no pain) to 10 (worst possible pain) how bad is your pain:



Is the pain in your arm(s):

- Worse than your neck _____
- Same as your neck _____
- Less than your neck _____

For A 100% Total Neck Pain _____ %
 Please Divide Your Pain Arm Pain _____ %

Is the pain in your leg(s):

- Worse than your back _____
- Same as your back _____
- Less than your back _____

For A 100% Total Back Pain _____ %
 Please Divide Your Pain Leg Pain _____ %

How long can you:

- Sit? _____ minutes
- Stand? _____ minutes
- Ride in Car _____ minutes

How far can you walk _____ blocks

Please List Any Activities That Make Your Problem:

- Worse _____
- Better _____

Patient / Guarantor Signature _____