PAIN SHEET		GENERAL EVALUATION

Patient Name: ______________________________ Account#: DOB: _______________

Referring Provider: ______________________________ Appointment Date: ______________________________

1. What was your chief complaint when you visited your doctor?_______________________________
____
2. What do you think caused your problem? (MVA, work injury, fall, etc)?______________________
____
____**Date of Injury**_______________________________
3. Describe your pain (eg.,burning, sharp, etc)____
____
4. Does the pain go down your Arm?______Your Leg?______In the back or front ________________
Left, Right or both? __________
5. Does Anything make the pain worse?(standing, sitting, lying down)?__________________________
____
6. Do you have any numbness/weakness and where?____
7. Have you had any bowel or bladder changes?____
8. Do you have any masses, lumps or swelling?____
9. Have you had any surgery in the area being scanned/x-rayed today? If so, when and what was done?____
____