

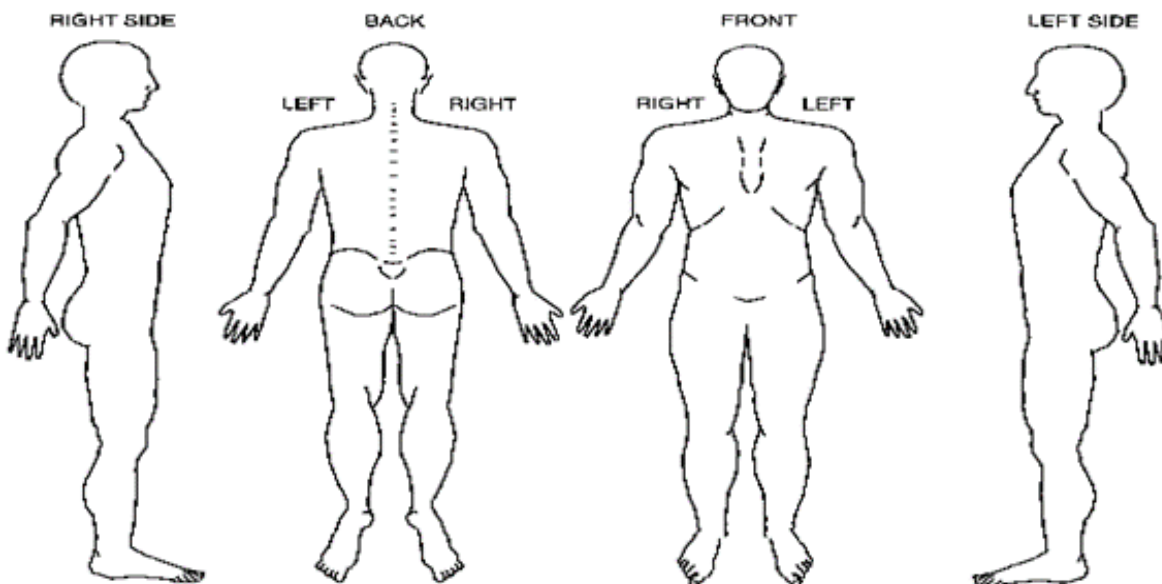


## Pain Self-Evaluation

### Pain Diagram

A=ACHE B=BURNING N=NUMBNESS P=PINS AND NEEDLES S=STABBING T=THROBBING

Mark the areas on the diagram where you feel pain. Use the symbols above to indicate your pain



On a scale of 0-10 (0=No pain, 10=Worst pain you have ever experienced)

What is your pain today?

0	1	2	3	4	5	6	7	8	9	10
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Over the last month

What has been your lowest pain level?

0	1	2	3	4	5	6	7	8	9	10
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What has been your highest pain level?

0	1	2	3	4	5	6	7	8	9	10
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What has been your pain level during activity?

0	1	2	3	4	5	6	7	8	9	10
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Patient Name: \_\_\_\_\_

1. How long does your pain last daily?

1-4 hrs/day

4-8 hrs/day

8-12 hrs/day

12-24 hrs/day

2. When is your pain the worst?

Morning

Afternoon

Evening

Nighttime

3. What makes your pain better?

\_\_\_\_\_

\_\_\_\_\_

4. What makes your pain worse?

\_\_\_\_\_

\_\_\_\_\_

5. How long a can you do the following (in minutes):

Sit continuously \_\_\_\_\_ Stand continuously \_\_\_\_\_

Drive continuously \_\_\_\_\_ Walk continuously \_\_\_\_\_

6. What actions have you taken to get better?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. Have you ever seen a chiropractor?    Y / N

a. If yes, when \_\_\_\_\_

After treatment did your pain (please circle one):    increase    decrease    stay the same

8. Have you ever had acupuncture?    Y / N

a. If yes, when \_\_\_\_\_

After treatment did your pain (please circle one):    increase    decrease    stay the same

Patient Name: \_\_\_\_\_

Print Name

Signature

Date

- OR -

Patient  
Representative: \_\_\_\_\_

Print Name & Relationship to Patient

Signature

Date