

PATIENT PAIN FORM

OFFICE USE ONLY

Claim # _____

DOI: _____

NAME: _____

DATE: _____

1. Complaints or Symptoms _____

2. Is this injury accident related? () Yes () No

a) Work related? _____

b) Auto accident _____

c) Other? Please explain: _____

3. What activity makes it better or worse? _____

4. Comments: _____

Please circle the level of pain you currently have:

Pain Free _____ 1 2 3 4 5 6 7 8 9 10 _____ Extreme Pain

Using the symbols below, mark on the pictures where you feel pain:

Numbness ===

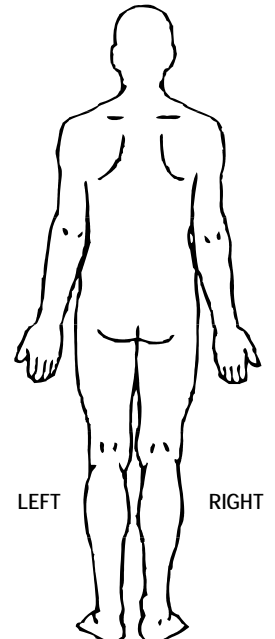
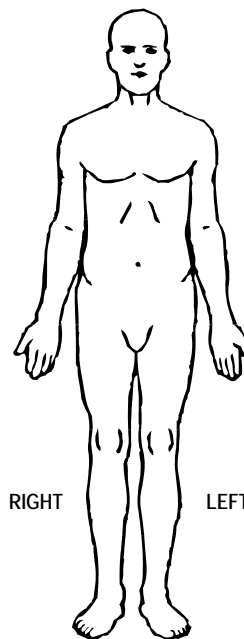
Dull Ache 000

Burning xxx

Sharp, stabbing ///

Pins, needles +++

Other _____ ...



PATIENT'S SIGNATURE