LAST NAME:_____**FIRST NAME:** _____**MI:** _____

AGE: _____

PLEASE CIRCLE THE NUMBER THAT BEST INDICATES THE LEVEL OF YOUR **CURRENT PAIN**

NO PAIN - 0 1 2 3 4 5 6 7 8 9 10 - SEVERE PAIN

LOW BACK PAIN	**NO PAIN 0 1 2 3 4 5 6 7 8 9 10 SEVERE PAIN**
LEG PAIN	**NO PAIN 0 1 2 3 4 5 6 7 8 9 10 SEVERE PAIN**
NECK PAIN	**NO PAIN 0 1 2 3 4 5 6 7 8 9 10 SEVERE PAIN**
ARM PAIN	**NO PAIN 0 1 2 3 4 5 6 7 8 9 10 SEVERE PAIN**

OTHER PAIN (_____**)**

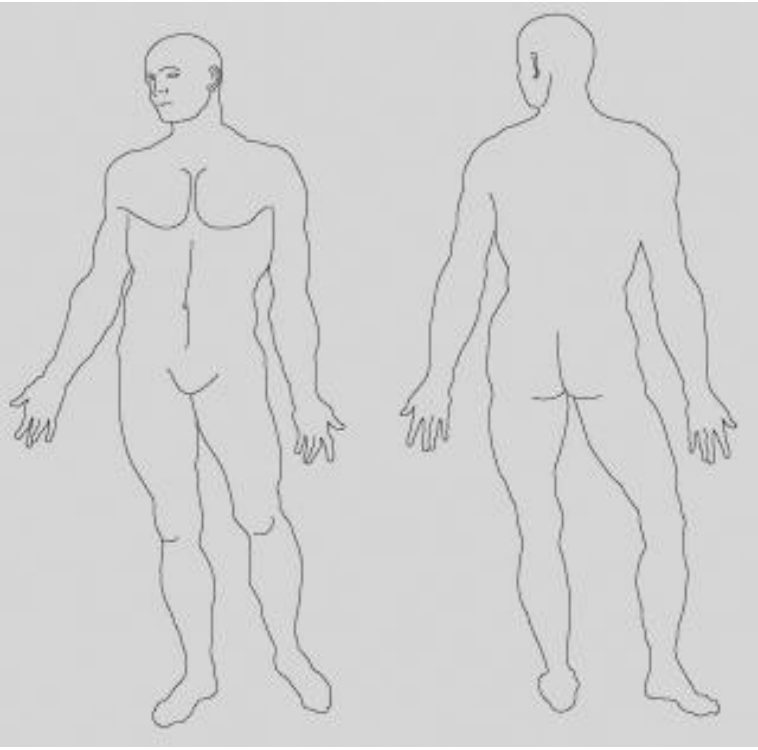
ARE YOU EXPERIENCING THE FOLLOWING SYMPTOMS:
WEAKNESS IN YOUR ARMS___ LEGS___ ARMS___ LEFT___ RIGHT___

DIFFICULTIES WITH BOWEL AND/ OR BLADDER

IF YOU ARE EXPERIENCING NECK, LOW BACK, ARM, LEG OR OTHER PAIN, PLEASE ANSWER THE FOLLOWING:

PLEASE MARK THESE DRAWINGS ACCORDING TO WHERE YOU HURT USING THE KEY BELOW TO ILLUSTRATE THE CHARACTER OF YOUR PAIN. MARK A CIRCLED "X" IN THE ONE PLACE YOUR PAIN IS MOST SEVERE.

SHOOTING-STABBING	**BURNING / ACHING**	**PINS & NEEDLES**	**NUMBNESS**
//////////	/\/\/\/\	+++++++	oooooo



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