

Date: 05/15/2015

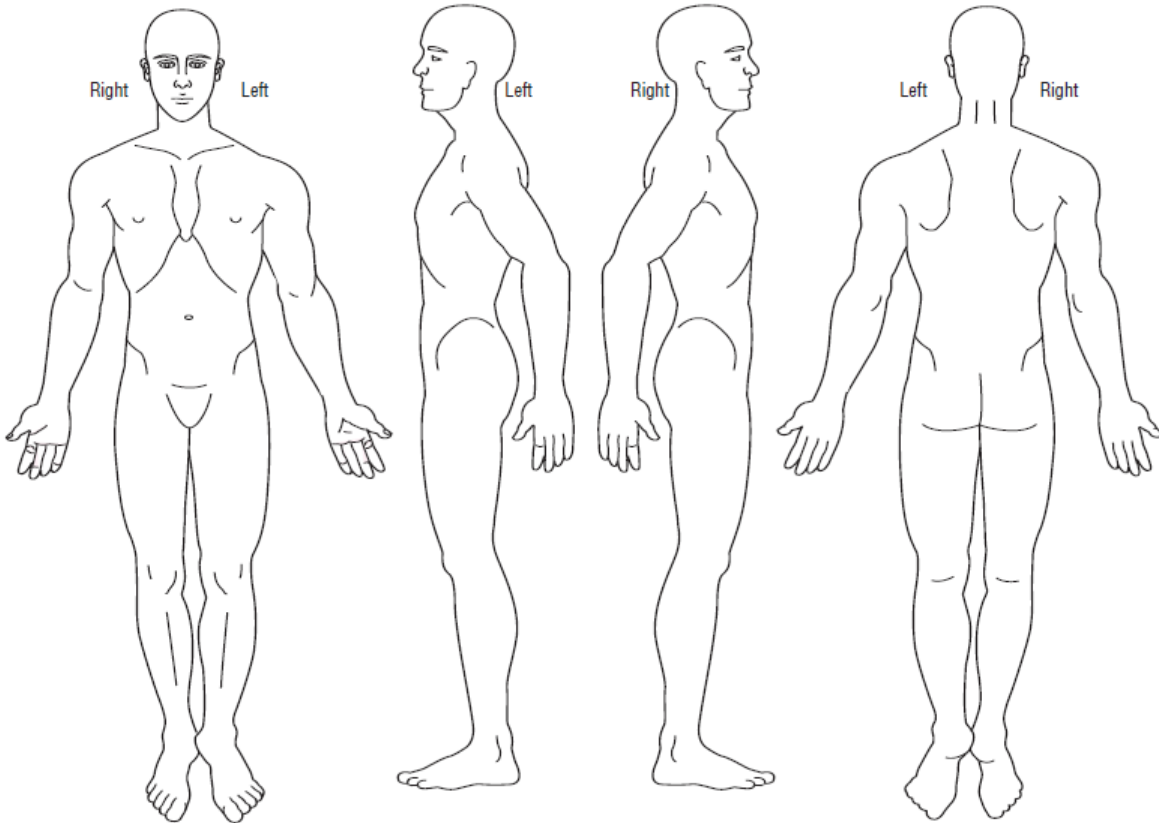
Name: «PName»

MRN #: «PNumber»

Birthdate: «PDOB»

IMPORTANT: Please use symbols below to indicate the location & level of your pain during the last week, with "0" being no pain and "10" being intensely severe pain.

Pain level now	0 1 2 3 4 5 6 7 8 9 10	Pins/Needles	0 0 0 0
At its worst	0 1 2 3 4 5 6 7 8 9 10	Numbness	= = = =
At its best	0 1 2 3 4 5 6 7 8 9 10	Burning	X X X X
At night	0 1 2 3 4 5 6 7 8 9 10	Stabbing	/ / / /
		Ache	^ ^ ^ ^



Please answer the following questions:

What is your percentage of overall improvement since your initial visit? 0% 10% 25% 50% 75% 90% 100%

What makes your pain **WORSE**? Sitting Standing Walking Lying Bending Forward Bending Backwards
Other _____

What makes your pain **BETTER**? Sitting Standing Walking Lying Bending Forward Bending Backwards
Other _____

Patient Signature: _____

Date: _____