CHIRO REHAB CENTER

220 Hamburg Turnpike Suite 14A • Wayne, NJ 07470 | T:(862) 336-1600 • F:(862) 336-1601

Pain Evaluation Form

Name: ______________________________ Date: ______________

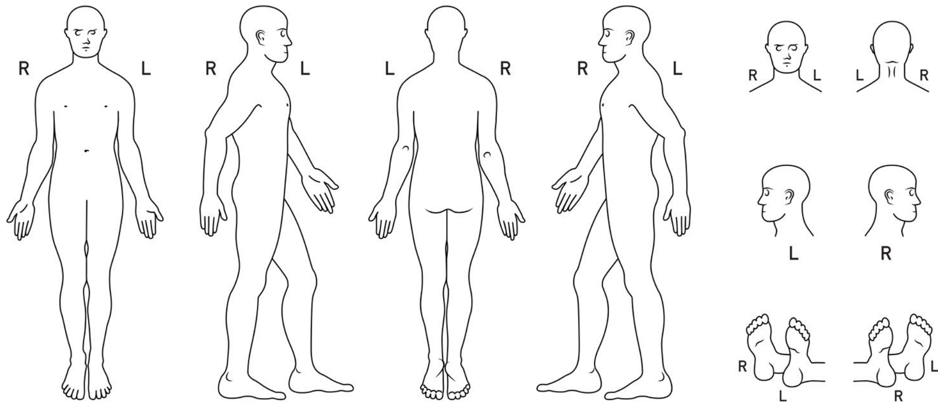
Circle where it hurts on the chart & use the lines below to best describe the type of pain you feel.

____

____

____

sharp, aching, tingling, throbbing, numbness, shooting, deep, dull, hot, cold, burning, cramping, itchy, swelling, spasm, sensitive, etc.



1. Do you take any medication for your pain? (*Over-the-Counter or Prescription*) ◯Yes ◯No

If yes, what: ______________________________

Frequency? ______________________________

2. Does the pain radiate? ◯Yes ◯No ◯Sometimes

3. Is the pain constant? ◯Yes ◯No ◯Sometimes

4. Does anything cause, increase, or aggravate the pain you're experiencing? ◯Yes ◯No

If yes, what: ______________________________

5. Does anything decrease or alleviate the level of pain you're experiencing? ◯Yes ◯No

If yes, what: ______________________________

6. Over the past month, what percentage has your pain interfered with your daily activites?

(i.e.: housework, washing, dressing, walking, eating, sleeping, going to the bathroom, climbing stairs, getting in or out of beds and chairs, etc.) [ ]

7. Has the area where you experience pain increased or decreased in size since you began treatment with us?

◯Increased ◯Decreased ◯No change

8. Has your overall level of pain increased or decreased since beginning treatment?

◯Increased ◯Decreased ◯No change

9. Are you performing your exercises as instructed? [ ]

10. Evaluate your pain over the past week. On the pain scale below, please place a "**C**" at your current pain level, followed by a "**W**" for the worst level of pain you experienced, and an "**L**" for the least level of pain over the course of the past week. *(1 Minimum - 10 Maximum)*

The following section is to be completed by your Doctor

	Flex.	Ext.	R. Rot.	L. Rot.	R. Lat.	L. Lat.
Cervical						
Lumbar						