PLEASE COMPLETE PATIENT PORTION

Patient Name:_____Date: _____

What is your Chief Complaint? _____

What makes your pain worse?_____

What makes your pain better?_____

Percentage relief from your last injection/procedure? _____

PLEASE SHADE AREA OF BODY AFFECTED BY PAIN/NUMBNESS

Numbness	**Pins & Needles**	**Ache**	**SharpPain**
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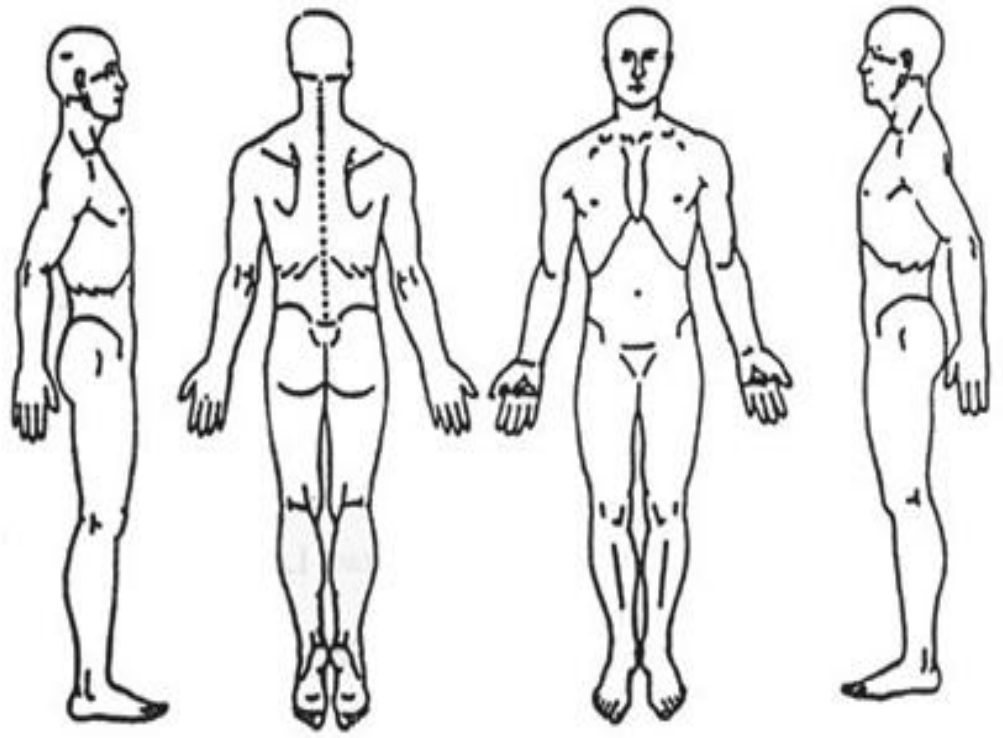
Right Left Right Right Left Left



PLEASE LIST YOUR AREAS OF CONCERN FROM WORST TO LEAST AMOUNT OF PAIN:

1)_____ 2) _____ 3) _____

Are you taking **NEW** Medications? Y / N if yes, please list_____

Have you had Physical Therapy? Y / N if yes, when? _____

REVISED: 9/28/2016