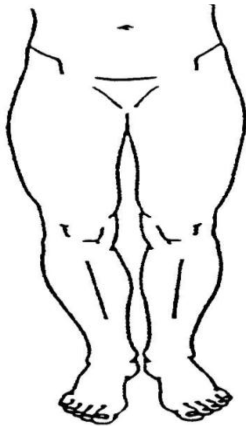
LOW BACK, PELVIS, & LOWER EXTREMITY INTAKE FORM

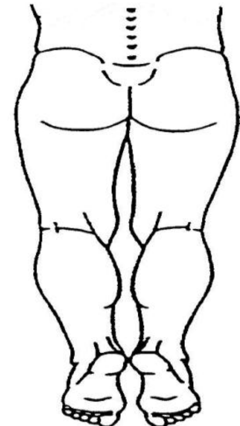
PATIENT NAME:_________________________________ DATE:________________ FILE#________________

PAIN DRAWING



Mark the area where you feel the described sensation(s). Use the appropiate symbol(s), mark areas of radiating pain, & include all affected areas.

Numbness: -------
Pins & Needles: ooooooo
Burning Pain: xxxxxxx
Stabbing Pain: ///////
Aching Pain: (((((((



VISUAL ANALOG SCALE

Please circle the pain level that most accurately represents your pain drawn above:

NO PAIN:--UNBEARABLE PAIN												
(A)Right Now:	0	1	2	3	4	5	6	7	8	9	10	________________
(B)Average Pain:	0	1	2	3	4	5	6	7	8	9	10	________________
(C)At Best:	0	1	2	3	4	5	6	7	8	9	10	________________
(D)At Worst:	0	1	2	3	4	5	6	7	8	9	10	________________

HISTORY OF PRESENT ILLNESS

1. When did this pain start (be as exact as possible)?____
2. Did anything contribute to the onset of this pain?____
3. Did the pain come on: □Suddenly or □Gradually?
4. How would you describe the pain: □Mild □Moderate □Severe?
5. Is the pain: □Constant □Comes & Goes □Other____
6. Has the pain been getting □Better □Worse □Same since the date listed above?
7. What makes the pain better?____
8. What makes the pain worse?____
9. Are you currently taking any store bought or prescription medications for the pain: □Yes □No?
10. Have you sought any other professional care for this pain?____________________________________
11. Have you had any surgeries or major traumas to the area above? ____________________________
12. Is there anything else you would like us to know?____