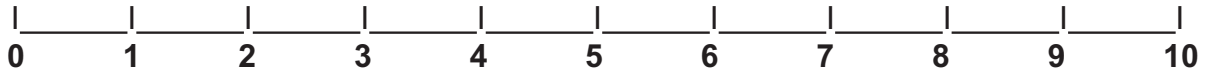




PAIN DRAWING

PATIENT I.D. _____

1. How much pain in general can you tolerate?



No Pain

Worst pain Imaginable

2. Where is your pain now?

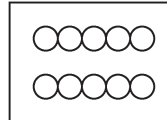
Mark the areas on your body using the appropriate symbols to describe your symptoms.

TYPE OF PAIN **SYMBOL**

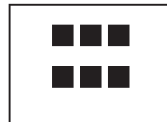
Ache



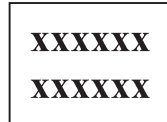
Numbness



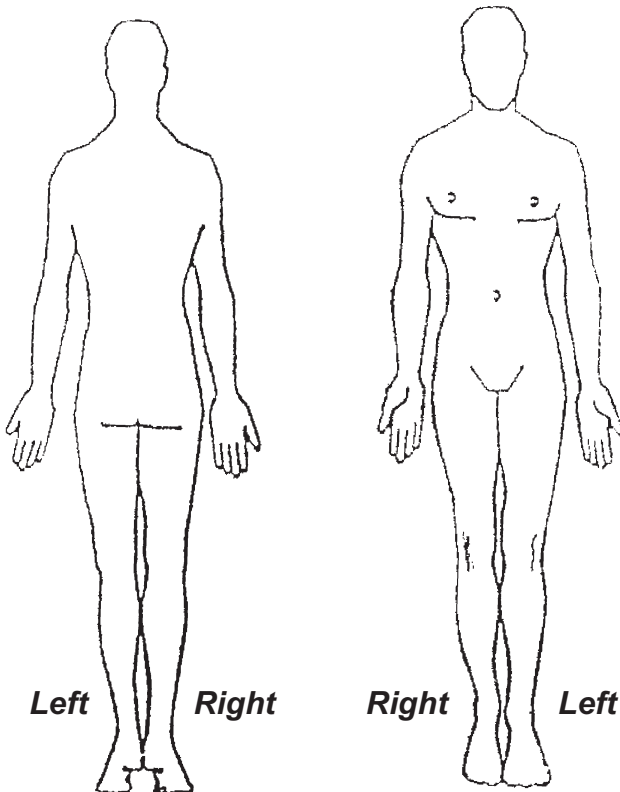
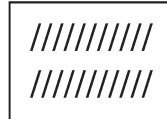
Pins & Needles



Burning



Radiating Pain



3. How bad is your pain?

Neck pain _____ %

Arm pain _____ %

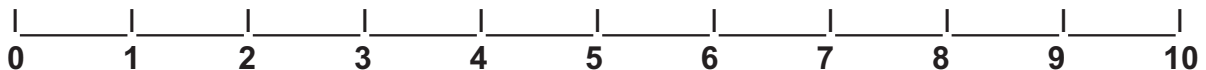
Total 100%

Back pain _____ %

Leg pain _____ %

Total 100%

4. How bad is your pain now?



No Pain

Worst pain Imaginable

5. The duration of pain:

- Continuous Positional Intermittent (On/Off) Unable to Rate

6. Have you taken pain medication in the past 24 hours?

- YES NO



CEDARS-SINAI MEDICAL CENTER
SPINE CENTER

Personal information

Last Name: _____ First Name: _____

Age: _____ Date of birth: _____ Occupation: _____

Social History

Marital Status: Single Married Separated Divorced Widowed

Do you live alone: Yes No

How many children do you have? _____ None

Will you have a caregiver to assist you if surgery is needed? Yes No

Are you currently working? Yes No

Have you lost work due to your back problem? Yes No

Do you have stairs in your home? Yes No

Do you think you are at risk for a fall? Yes No

Current Problems

Chief complaint or reason for visit: _____

Date symptoms began: _____

Cause of present problem (e.g. work related injury, auto accident, slip-and-fall, etc.):

Past History

Past or ongoing medical problems (e.g. high blood pressure, stroke, diabetes, heart condition, cancer, etc.):

(If more space is needed, please attach on a separate sheet.)



CEDARS-SINAI MEDICAL CENTER.
SPINE CENTER

Previous Surgeries

Name of operation:

Date:

_____	_____
_____	_____
_____	_____

Other Information

Do you smoke? Yes No

If yes, number of cigarettes per day: _____

Do you drink alcohol? Yes No

If yes, what kind of drink(s)? _____

Number of drinks per week: _____

Have you had recent imaging studies? Yes No

_____ MRI _____ CT scan _____ Plain X-rays

Allergies

Please list all allergies and response such as rash, itching, difficulty breathing, or unknown:

Drug name	Reaction
_____	_____
_____	_____
_____	_____

Medications

Please list all current medications, over the counter drugs, vitamins and herbals:

(If more space is needed, please attach on a separate sheet.)

Name	Dosage / Amount	Time of day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature	Date	Time
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