

PPM Pennsylvania Pain Management

PATIENT PAIN HISTORY INFORMATION

All information provided will be kept CONFIDENTIAL.

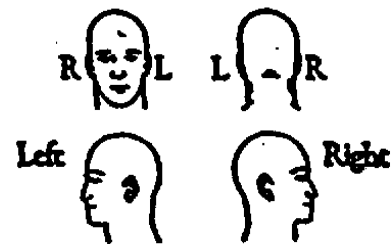
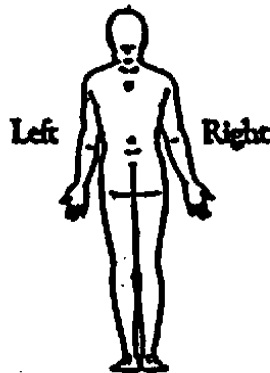
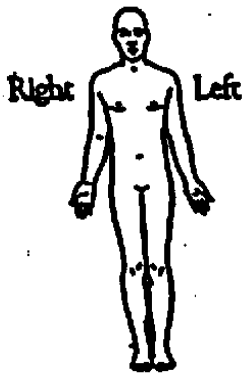
Name	Date of Birth	DATE
------	---------------	------

PLEASE DESCRIBE BRIEFLY THE REASON YOU ARE BEING SEEN TODAY.	
LOCATION OF PRIMARY PAIN AREA	
WHEN DID THE PAIN BEGIN?	
DESCRIBE ANY INCIDENT THAT MAY HAVE CONTRIBUTED TO THE ONSET OF YOUR PAIN:	
RATE YOU PAIN ON A SCALE OF 0 / 10: 0 = NO PAIN 10 = WORST PAIN YOU CAN IMAGINE During an average day while performing your normal daily routine your pain level is:	
Usually	At its worst
LOCATION OF OTHER PAINFUL AREAS	

Location and Description of Pain Complaints: Please indicate Right, Left or Both Sides

Location	R	L	SHARP	DULL	SHOOTING	ACHING	BURNING	STABBING	THROBBING	COLD	HOT	NUMB
HEAD												
NECK												
UPPER BACK												
LOW BACK												
ABDM/GROIN												
ARM/SHLDR												
HAND/WRIST												
LEG/HIP												
FOOT/ANKLE												

Please use an X to mark the images below indicating the location of your pain.



Does the pain travel? (Example: From neck to arm or back to leg)	Yes	No
Describe briefly what makes your pain become...	Worse	Better