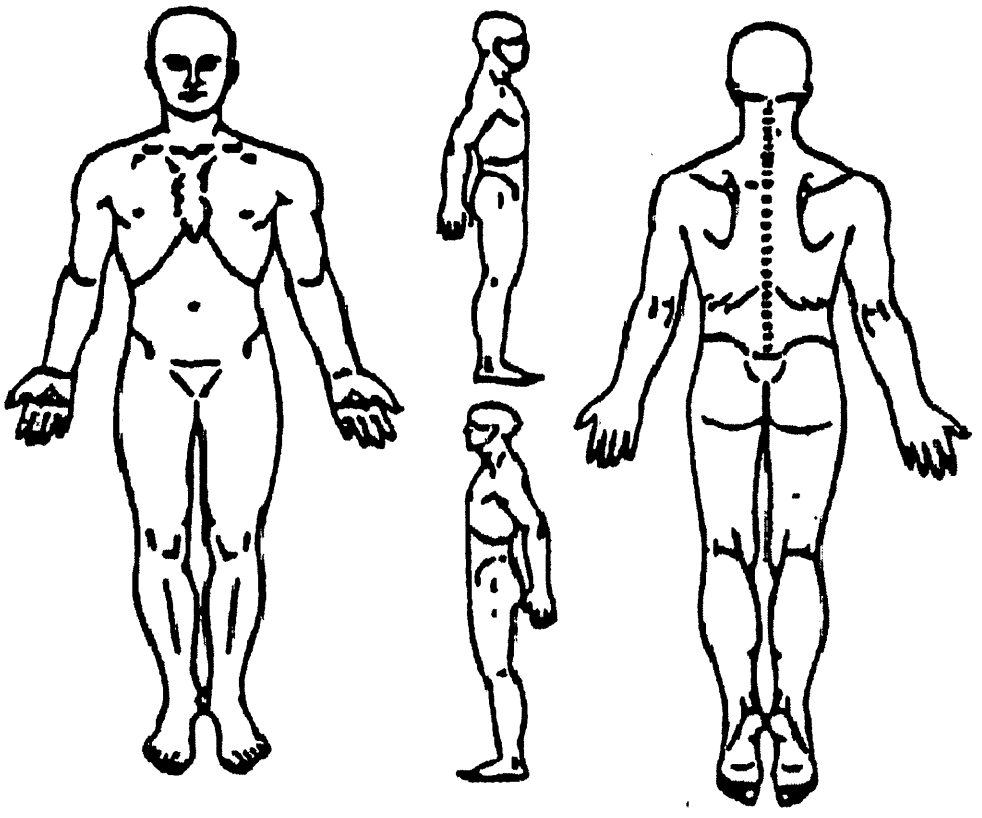
How Are You Doing

This form is to be completed at initial exam **and** at each follow-up appointment.

Patient Name: _____ Date: _____

Primary Complaints: Please mark area and circle Quality of Pain that pertains to your visit today



Quality of Pain

Headache/Migraine

Stabbing

Numbing

Tingling

Dull/Achy

Sharp

Shooting

Pin/Needles

Fatigue

Burning

Tightness

Throbbing

Diffuse

Popping/Grinding

Patient Pain Evaluation

Please rate the following pain levels: pain scale is based on 0 – 10 0 = pain free/no pain, 10 = worst pain imaginable

Current level of pain: 0 1 2 3 4 6 7 8 9 10

Worst pain level in **PAST 24 HOURS**: 0 1 2 3 4 5 6 7 8 9 10 Least level in **PAST 24 HOURS**: 0 1 2 3 4 5 6 7 8 9 10

What time of day is your pain level at its worst: Morning Mid-day Evening Bed-time

Pain Frequency

Pre-treatment: Occasional 0-25% Intermittent 25-50% Frequent 50-75% Constant 75-100%

Post-treatment: Occasional 0-25% Intermittent 25-50% Frequent 50-75% Constant 75-100%

Currently, what is the duration of post-treatment relief (# of days) _____ or Unknown (first session)