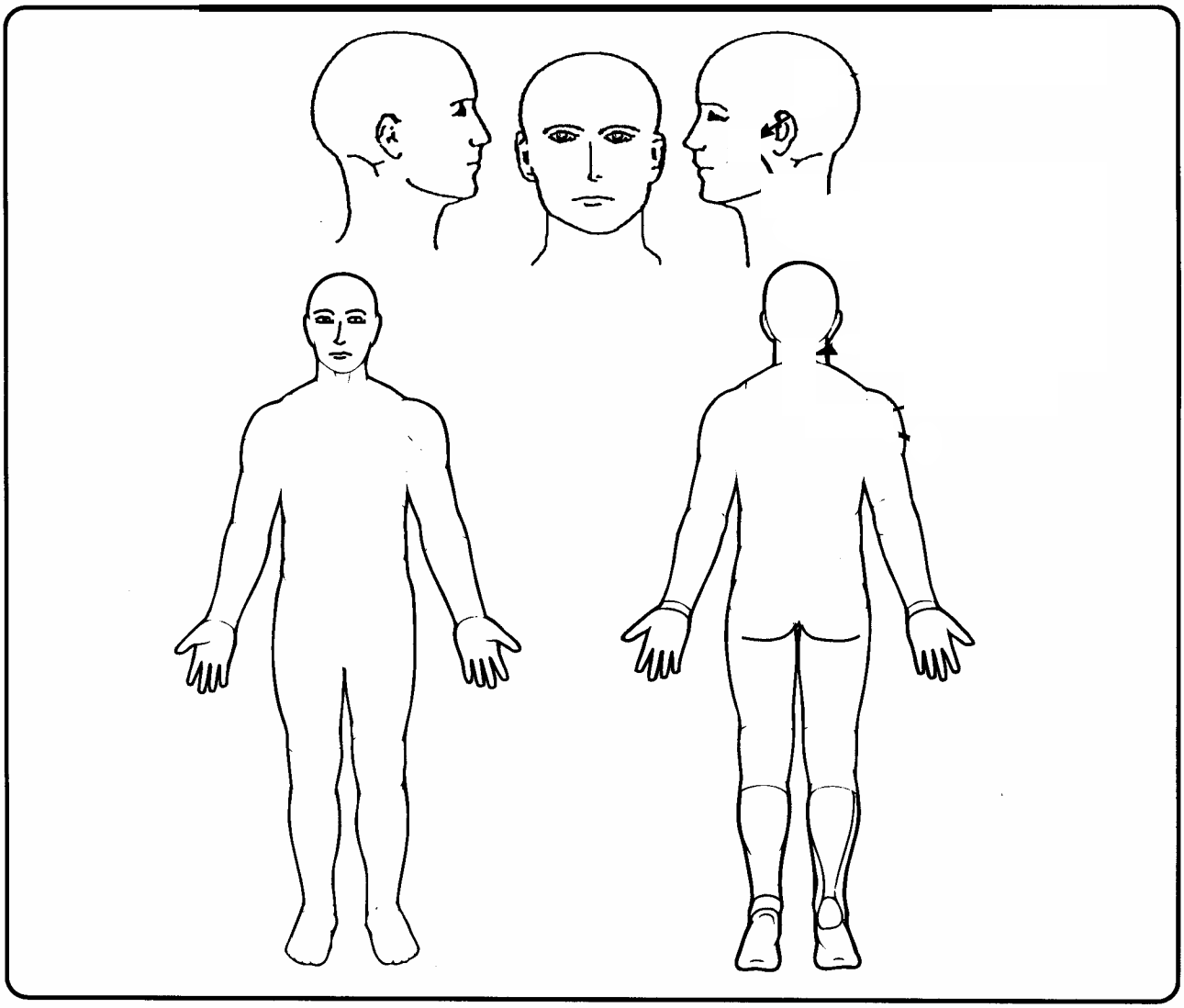
Assessment treatment form



Patients Name: _____DOB ___/___/____ Date: _____

1. How long have you had pain? _____
2. When did the pain start? _____
3. What type of Pain? Sharp Burning Dull Radiating
4. How often does the pain occur? _____
5. Location of Pain? _____
6. Pain Score (#1 being the least amount, #10 as the highest degree of pain)

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.