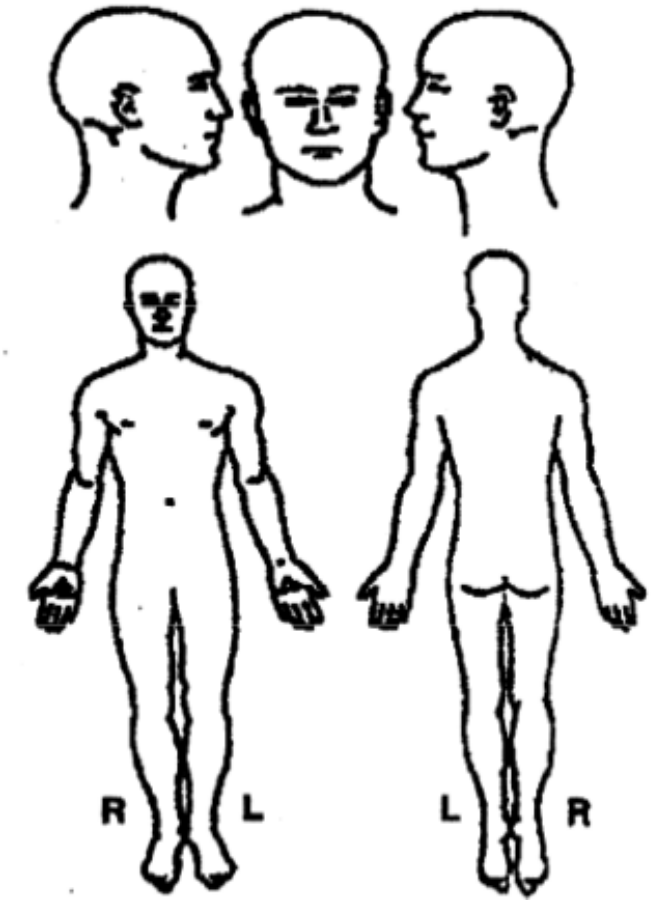
Physical Medicine Treatment Assessment Form

Patients Name: _____ DOB: ____/____/____ Date: _____



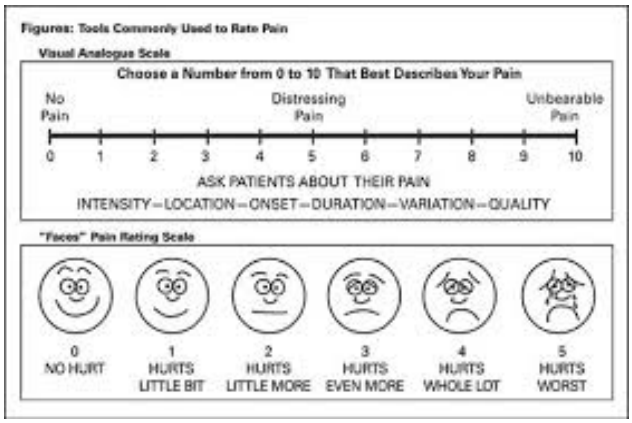
Please use the following symbols or letters on the drawing to the left to give our providers a reasonable map of the areas of your body and type of pain you are experiencing.

~ = Achy × = Sharp / = Stabbing

D = Dull C = Cramping :: = Pricking

o = Numbness B = Burning - = Radiating

» = Lightening S= Stiffness + = Muscle Spasm



1-2= I know it is there but forgotten with activity / **3-4=** It is starting to bother me at work or home / **5-6=** I can't perform my usual duties both at home or work

7-8= It effects every aspect of my life and it is nearly impossible to work or take care of myself / **9-10=** Just cut it off or get me to surgery

10's usually do not come to a doctor's office. They are typically an emergency room situation!

Location: _____ Location: _____ Location:_____

Pain Sore Complaint #1: _____ Pain Score Complaint #2: _____ Pain Score Complaint #3: _____

New Injury: _____ Date of Onset: _____

Notes:_____

_____

_____

_____

_____

_____

Provider: _____ Date: _____