CLEVELAND BACK & PAIN MANAGEMENT CENTER, INC.

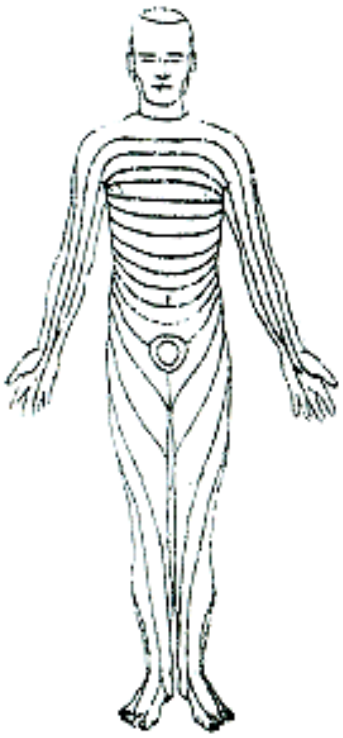
PAIN DIAGRAM

TO BE COMPLETED BY PATIENT AT EACH OFFICE VISIT

NAME: _____ **DATE:** _____

PAIN LOCATION – SHADE IN PAINFUL AREA

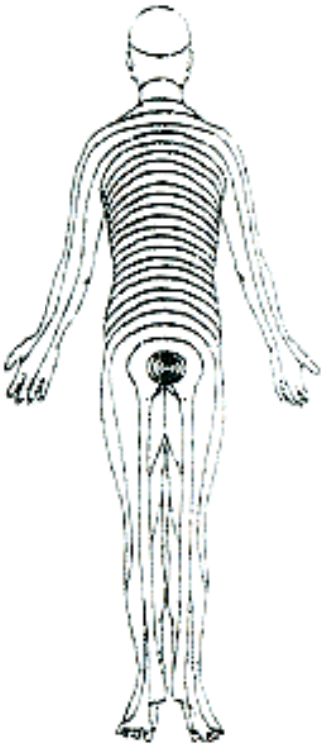
RIGHT **LEFT** **LEFT** **RIGHT**



Which words describe your problem.
Please check (✓)

____ Ache	____ Burning
____ Pins/Needles	____ Stabbing
____ Numbness	____ Hot
____ Pressure	____ Cold
____ Weakness	____ Vibration

Other _____



1. ON A SCALE FROM 0 TO 10 HOW BAD ID YOUR PAIN TODAY? 0 = **NO PAIN** 10 = **WORST PAIN EVER**

   0 1 2 3 4 5 6 7 8 9 10

2. SINCE MY LAST VISIT, I AM: _____ **BETTER** _____ **SAME** _____ **WORSE**
3. ARE YOU WORKING? ☐ **YES** ☐ **NO**
4. ARE YOU TAKING ANY NEW MEDICATIONS OR HAVE YOU RECEIVED ANY MEDICATIONS FROM ANY OTHER DOCTORS (EMERGENCY ROOM & DENTAL VISITS INCLUDED)? ☐ **YES** ☐ **NO** **LIST**: _____
5. HAVE YOU HAD ANY SIDE EFFECTS OR ADDICTION PROBLEMS WITH YOUR MEDICATION? ☐ **YES** ☐ **NO**
6. SIDE EFFECTS: ☐ **NONE** ☐ **NAUSEA** ☐ **VOMITING** ☐ **CONFUSION** ☐ **SLEEPINESS** ☐ **FATIGUE** ☐ **CONSTIPATION** ☐ **ADDICTION** ☐ **DEPENDENCY** ☐ **OTHER** _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND THAT I HAVE ASKED DR. NICKELS AND/OR HIS PARTNERS ANY QUESTIONS I HAVE ON RISKS, BENEFITS OR ALTERNATIVE PAIN MANAGEMENT TREATMENTS.

PATIENT SIGNATURE:_____ **DATE:**_____ **WITNESS:** _____