CASCADE orthopedic MASSAGE

☐ 18750 Willamette Dr. Ste F
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Pain Assessment Form

Patient/Client Name:_________________________

History of Spine Symptoms:

1. Please check the following symptoms that you have:
   ☐ back pain ☐ leg pain ☐ tingling/numbness in leg
   ☐ neck pain ☐ arm pain ☐ tingling/numbness in arm
2. When did your symptoms begin? ____
   ____
3. Are you experiencing any problems controlling your bladder or bowel?
   Bowel: ☐ Yes ☐ No
   Bladder: ☐ Yes ☐ No
4. Do you wake up at night because of your pain? ☐ Yes ☐ No
5. What makes your pain better?
   ☐ lying down ☐ sitting ☐ walking ☐ bending
   Other: ____
6. What makes your pain worse?
   ☐ lying down ☐ sitting ☐ walking ☐ bending
7. Are you currently working?
   ☐ yes ☐ no, due to pain ☐ retired ☐ disabled

Past Spine Treatment History:

8. Have you ever had back or neck pain before?
   ☐ yes ☐ no If so, When? ____
9. Have you had back or neck surgery?
   ☐ yes ☐ no
10. What diagnostic tests have you had?
   ☐ CT Scan ☐ MRI ☐ X-Ray ☐ EMG/NCS
11. Did you have the following treatments for your pain?
   Injections: ☐ yes ☐ no
   Did they help? ☐ yes ☐ no
   Physical Therapy: ☐ yes ☐ no
   Did it help? ☐ yes ☐ no
   What did it consist of? ____
   ____
12. Rate your pain on a scale of 1 to 10, with 1 being no pain and 10 the most severe pain. Please use an X

Mark these drawings according to where you hurt. Please use the scale below to indicate which sensations you are feeling.

/ / / Stabbing

XXX Burning

+ + + Aching

= = = Numbness

0 0 0 Pins & Needles