

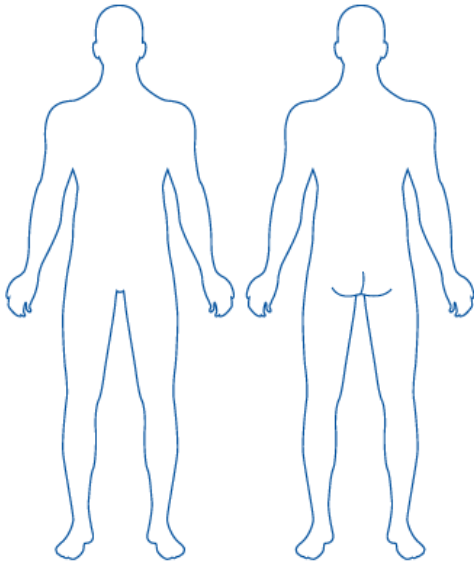


RE-EVALUATION FORM

Your Name: _____ Today's Date: ___ / ___ / _____

Are you experiencing any new pain/ symptoms : _____

Indicate (with an 'X') on the drawings below where you have pain/ symptoms



I experience pain/ symptoms:

- Constantly (76-100% of the time)
- Frequently (51-75% of the time)
- Occasionally (26-50% of the time)
- Intermittently (1-25% of the time)

The type of pain I am experiencing is:

- Sharp Numb Dull Tingly Diffuse Sharp with motion Achy
- Burning Stabbing with motion Shooting Electric with motion Stiff
- Shooting with motion Other: _____

My Symptoms are: Getting worse Staying the same Getting Better

On a scale from 1-10 (10 being worst) my pain/ symptoms are a: _____

<p>This problem still interferes with my work:</p> <p><input type="checkbox"/> None <input type="checkbox"/> A little <input type="checkbox"/> Moderately <input type="checkbox"/> A lot <input type="checkbox"/> Extremely</p>

<p>This problem still interferes with my social activities:</p> <p><input type="checkbox"/> None <input type="checkbox"/> A little <input type="checkbox"/> Moderately <input type="checkbox"/> A lot <input type="checkbox"/> Extremely</p>
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Patient Signature: _____ Date: ___ / ___ / _____

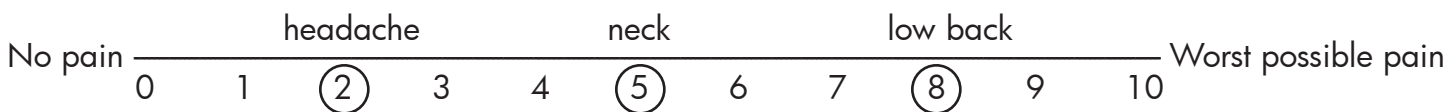


PAIN SCALE

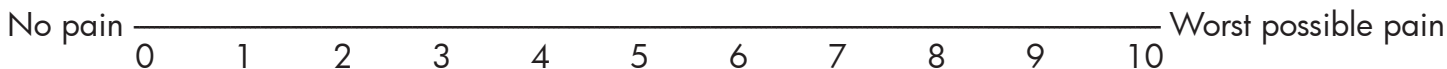
Your Name: _____ Today's Date: ___ / ___ / _____

Please circle the number that best describes the question being asked and label the pain. If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

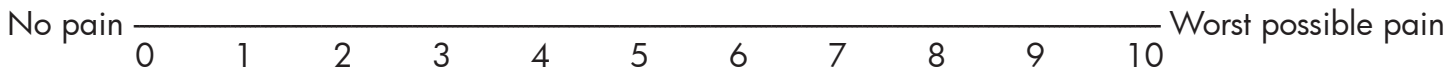
Example:



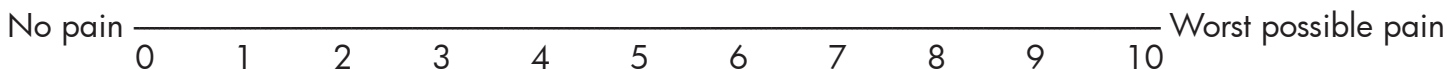
What is your pain right now?



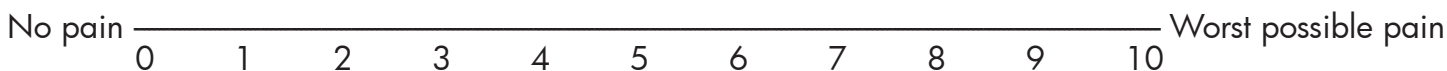
What is your typical or average pain?



What is your pain level at its best?



What is your pain level at its worst?



Comments: _____

