



DEER VALLEY SPINE CENTER

Name _____

Date _____

Where is your pain? Back Leg Neck Arm When did your pain start? _____

Is your pain related to an injury? _____

What activities make the pain worse? _____

What activities or positions make the pain less? _____

Do you have Numbness Yes No Tingling? Yes No Weakness? Yes No

How much time have you lost from work? _____

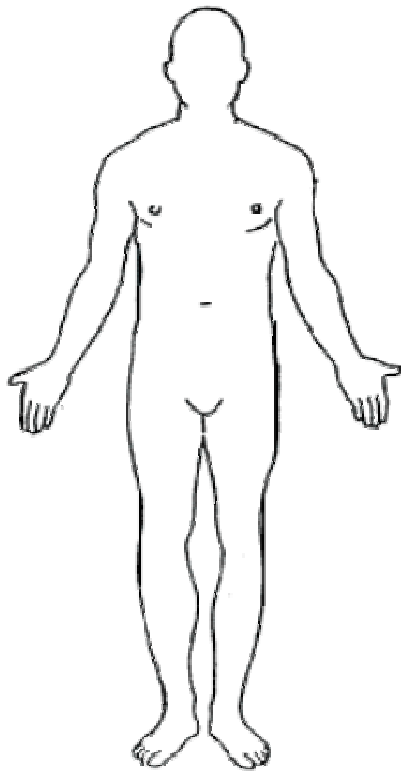
Have you seen another physician? Yes No

If so, Name of Doctor _____ His or Her Treatment(s) _____

Please list all previous neck or back surgeries and the dates _____

PAIN DIAGRAM

Draw the location of your pain on the body outlines below using the type of marks indicated below.



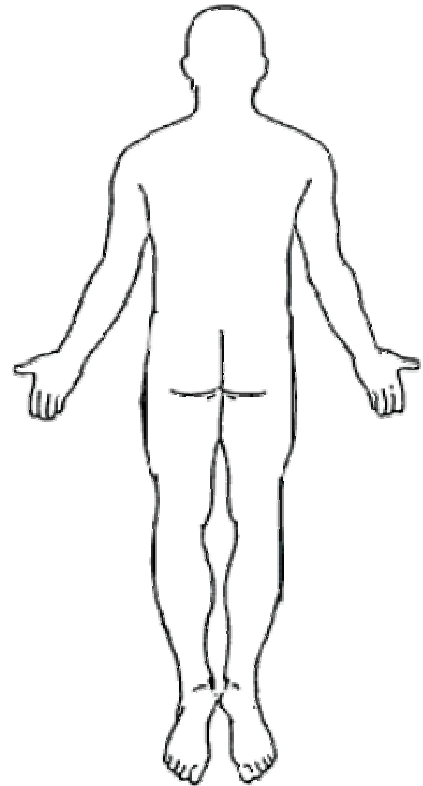
Numbness
#####

Pins and Needles
00000

Burning
xxxxx

Stabbing
/////

Ache
^^^^^



Pain Line: Please mark the line to indicate your pain level.

No Pain

0%

Worst Possible Pain

100%