Pt Name: _____ DOB: _____

When did your pain first start? (date or approx. month/year): _____

When did it worsen? (date and event, if applicable) _____

Rate the severity of your pain on a scale from 1 to 10, with 1 being the least painful and 10 being the most severe:

1 2 3 4 5 6 7 8 9 10

Type of pain (circle all that apply):

Aching Cramps Numbness Shooting Swelling Tingling

Burning Dull Sharp Stiffness Throbbing

Does the pain interfere with any of the following activities of daily living? (Circle all that apply)

Bathing Feeding Grooming Sleep Work

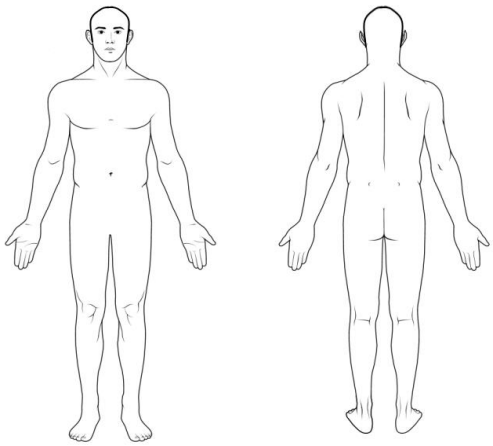
Dressing Food preparation Housework Toilet hygiene

How often are you having pain? _____ Constant _____ It comes and goes

Activities or movements that are painful to perform: (circle all that apply)

Bending Lying down Sitting Standing Walking

Mark "X" on the picture where you are having pain, numbness or tingling:



In the past 6 months, have you received any formal therapy for this condition? ___Yes ___ No
If yes, when? _____

Do you perform home exercises/stretches for this condition? ___Yes ___ No

Have you received an Epidural Steroid Injection for this condition? ___Yes ___ No
If yes, when? _____

What percentage relief did the injection provide?
_____

For how long? _____ (hours, days, weeks, months)
When did the pain return? (date)
_____

Have you tried any of the following for pain relief?	YES	NO	Did this provide relief?	Name of Medication
Heat				
Ice				
Over the Counter Medications				
Prescription				

Are you claustrophobic (fear of being in a closed/confined place)? ____ Yes ____ No

Do you have metal in your body? ___ Yes ___ No If yes, where? _____