Meridian Health Solutions Pain Assessment Form Patient ID:______(office use only)

Which Diagnostic studies have been done to evaluate your pain? (Circle all that apply and bring copies of the reports or films if applicable)

- MRI
- CT Scan
- X-Ray
- EMG/Nerve conduction studies
- Bone Scan
- Blood Tests
- Other: ______________________________

Which treatments have been done for your pain? (circle all that apply)

- Injection Treatments
- Chiropractic
- Massage
- Physical Therapy
- Surgical Procedures: ______________________
  ____
- Other: ___________________________________

WHERE is your pain? Left/Right sided, or both? ____

WHEN did your pain begin?____

HOW did your pain begin?____

What makes your pain WORSE?____

What makes your pain BETTER?____

How does the pain affect your daily life?____

How does your pain CHANGE with time? ____

What does your pain feel like? (circle all that apply)

Warm. Hot. Cold. Sharp. Dull. Burning. Electricity. Stabbing. Tingling. Throbbing. Pounding. Crushing. Pulling. Cramping. Unbearable. Penetrating. Aching. Sore. Heavy. Tender. Blinding. Annoying. Agonizing. Tight. Numb. Squeezing. Other:____

Circle your areas of pain.
Rate the pain severity 0-10,
10 = highest pain.

Please note anything else you'd like for us to know about your pain: