CEDARS-SINAI MEDICAL CENTER
SPINE CENTER

PAIN DRAWING

PATIENT I.D.

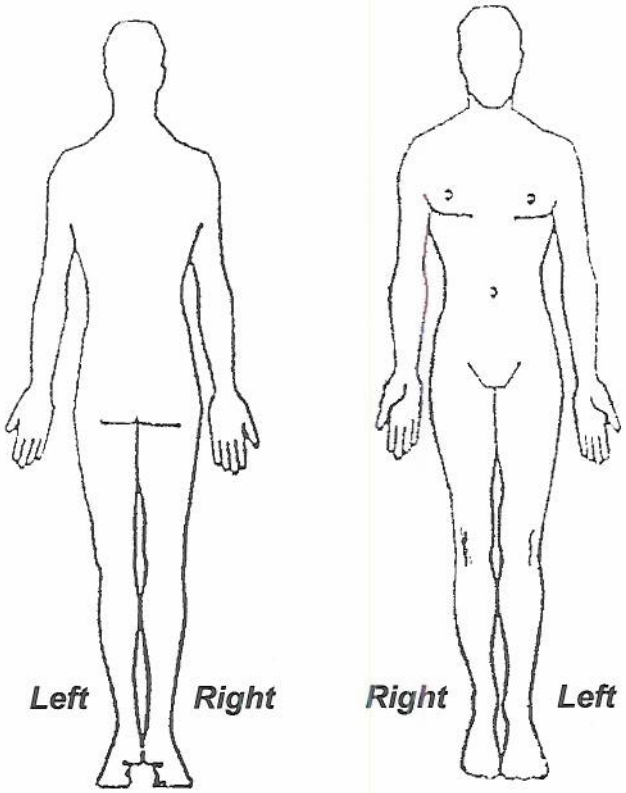
1. How much pain in general can you tolerate?

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst pain Imaginable

2. Where is your pain now?

Mark the areas on your body using the appropriate symbols to describe your symptoms.



TYPE OF PAIN	SYMBOL
Ache	<<<<< <<<<<
Numbness	○○○○○ ○○○○○
Pins & Needles	■■■ ■■■
Burning	XXXXXX XXXXXX
Radiating Pain	////////// //////////

3. How bad is your pain?

Neck pain _____ %

Arm pain _____ %

Total 100%

Back pain _____ %

Leg pain _____ %

Total 100%

4. How bad is your pain now?

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst pain Imaginable

5. The duration of pain:

❑ Continuous ❑ Positional ❑ Intermittent (On/Off) ❑ Unable to Rate

6. Have you taken pain medication in the past 24 hours?

❑ YES ❑ NO

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PHYSICIAN INFORMATION

PATIENT I.D.

Please provide your current Physician's information. Write down as much information you can provide (i.e., Name & City), so that we may keep them informed of your progress.

REFERRING PHYSICIAN

Name: _____
(Last, First)

Specialty: _____

Address: _____
(Street)

_____
(City, State, Zip Code)

Phone: (_____) _____ Fax: (_____) _____

INTERNIST / PRIMARY CARE PHYSICIAN

Name: _____
(Last, First)

Specialty: _____

Address: _____
(Street)

_____
(City, State, Zip Code)

Phone: (_____) _____ Fax: (_____) _____

OTHER PHYSICIAN INVOLVED IN YOUR CARE

Name: _____
(Last, First)

Specialty: _____

Address: _____
(Street)

_____
(City, State, Zip Code)

Phone: (_____) _____ Fax: (_____) _____

WORKMANS COMPENSATION *(IF APPLIES)*

Name: _____
(Last, First)

Specialty: _____

Address: _____
(Street)

_____
(City, State, Zip Code)

Phone: (_____) _____ Fax: (_____) _____