



Anne-Marie Medical Massage  
ADVANCED BODY CARE

# PAIN ASSESSMENT FORM

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**1. HISTORY OF PAIN / SYMPTOMS**

Check the following symptoms that you have:

- Back Pain                       Neck Pain
- Leg Pain                             Tingling/Numbness in Leg
- Arm Pain                             Tingling/Numbness in Arm
- Other

**2. WHEN DID SYMPTOMS BEGIN?** \_\_\_\_\_

**3. HAVE YOU EVER HAD THIS PAIN BEFORE?**  
 No       Yes - When? \_\_\_\_\_

**4. WHAT DIAGNOSTIC TESTS HAVE YOU HAD (MRI, X-Ray, CT Scan, Etc.) ?**  
\_\_\_\_\_

**5. HAVE YOU EVER HAD SURGERY FOR THIS ISSUE?**  
 No       Yes - What and When? \_\_\_\_\_

**6. HAVE YOU HAD ANY OF THE FOLLOWING TREATMENTS FOR YOUR PAIN?**  
Injections:  No                       Yes - Did it help? \_\_\_\_\_  
Physical Therapy:  No               Yes - Did it help? \_\_\_\_\_  
What type of Therapy? \_\_\_\_\_

**7. WHAT MAKES YOUR PAIN BETTER?** \_\_\_\_\_

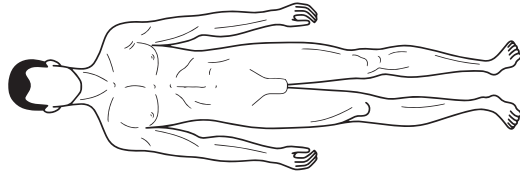
**8. WHAT MAKES YOUR PAIN WORSE?** \_\_\_\_\_

**9. DOES YOUR PAIN AFFECT ANY OF THE FOLLOWING?**  
 Movement                       Sleep/Rest  
 Emotions                             Activities - Explain: \_\_\_\_\_  
 Relationships                       Concentration  
 Bowels                                 Bladder  
 Other - Explain: \_\_\_\_\_

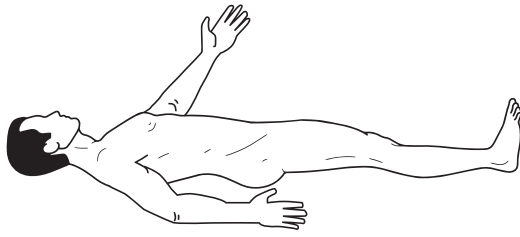
**10. MEDICATIONS**  
Have you been taking any medications for your pain? \_\_\_\_\_  
Have you taken medication today:  No       Yes - What Medication? \_\_\_\_\_

**11. ANY ADDITIONAL INFORMATION YOU FEEL IS IMPORTANT?**  
\_\_\_\_\_  
\_\_\_\_\_

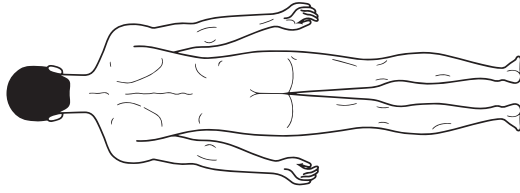
1. PLACE AN X at the location of your pain.



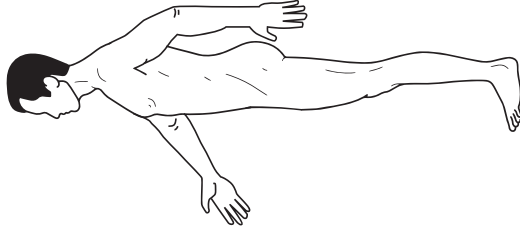
LEVEL	TYPE
10	Aching
9	Burning
8	Constant
7	Dull
6	Numbness
5	Sharp
4	Shooting
3	Stabbing
2	Tender
1	Throbbing
0	Tingling



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2. CIRCLE THE LEVEL of pain you experience.

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5	Sharp
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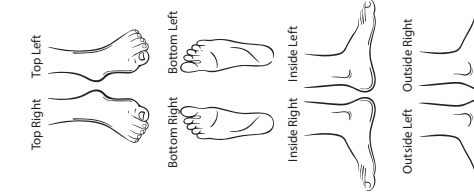
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