KLSMC Sports Medicine

The Pain Assessment Sheet
New patients with spine or joint pain

NAME _____ DOB_____

1. Please circle where your pain is

   Back pain leg pain tingling /numbness in leg

   Neck pain arm pain tingling numbness in arm
2. When did your symptoms start
3. Was there ever history of accident?
4. Are you having following problems
   a. Controlling bowel yes no
   b. Controlling bladder yes no
5. Do you wake up at night with pain
   a. Yes
   b. no
6. What makes your pain better
   a. Lying down
   b. Sitting
   c. Walking
   d. Bending
7. What makes your pain worse

   Lying down

   Sitting

   Walking

   Bending
8. Are you working currently?

   Yes

   No due to pain

   Retired

   Disabled
9. Previous treatment

   Have you had previous surgery to back or neck?

   Have you had any investigations?

   MRI Xray CT

   Did you have following treatment?

   Injections yes/no

   Did they help yes/no

   Physiotherapy yes/no

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10. Rate your pain on scale 1 to 10, 1 no pain, 10 severe pain. Please use X as a marker

I------1------2------3------4------5------6------7------8------9------10

Please mark where your pain is

/// stabbing

XXX burning

+++ aching

000 numbness or pins and needles