Spine and Sport Biomechanical Rehabilitation Center
Re-Evaluation Subjective Pain Form

Patient Name: ____ **Date:** ______________________

Please describe what you are currently experiencing/what you have experienced regarding your pain/symptom:

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Date of pain/symptom onset: ____

Today what is your current pain level?	**0 1 2 3 4 5 6 7 8 9 10**	**0 = No Pain**
What has your pain range been in the past 30 days?	**0 1 2 3 4 5 6 7 8 9 10**	**5 = Moderate Pain**
Have you gone to ER due to the pain/symptom?	YES NO	**10 = Excruciating Pain**

Do you have pain with coughing, sneezing, and/or bowel movements? YES NO (circle those that apply)

Do you have problems sleeping? YES NO **Explain:** ____

What is your best sleeping position? ___________________________ **Worst?** _____________________________

Symptoms increase with: ____

Symptoms decrease with: ____

What is your most tolerable position? (Circle) Lying Sitting Walking Standing All positions are the same

What is your least tolerable position? (Circle) Lying Sitting Walking Standing All positions are the same

Have you modified or discontinued any daily tasks? YES NO **Explain:** ___________________________________

Do you currently use splints, braces, support orthotics? If so circle and describe: _____________________________

Have you had diagnostic tests for pain/symptom? (Circle) X-Rays MRI CT Scan **Other**: _______________________

List any surgeries/ injuries since your last visit: ____

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List all current medications and condition for medication below: ____

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Additional Comments you would like the therapist to know:

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