

**SPINE AND SPORT BIOMECHANICAL REHABILITATION CENTER**

2816 East Beltline Lane NE • Grand Rapids, MI 49525 • Phone (616) 361-1210 • Fax (616) 361-8662

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ASSESSMENT OF SHINGLES**

Please describe what you are currently experiencing or what you have experienced in the past regarding your complaint / pain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your pain: (please circle)    Constant (continuous)    Intermittent (on/off hourly)    Episodic (on/off morning, noon, night)

What is your current level of pain? (Circle) 0 1 2 3 4 5 6 7 8 9 10

0 = absence of pain 5 = moderate pain 10 = excruciating
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What has your pain range been in the past 30 days? 0 1 2 3 4 5 6 7 8 9 10

When did you first start to experience pain in the shingles outbreak area? \_\_\_\_\_

Are skin lesions present? YES NO Date lesions appeared: \_\_\_\_\_ Location: \_\_\_\_\_

Have you had chicken pox? YES NO Age: \_\_\_\_\_ Have you had a chicken pox vaccine? YES NO Age: \_\_\_\_\_

Have you been diagnosed for Shingles by a physician? YES NO When: \_\_\_\_\_

Have you had a Shingles vaccine? YES NO Date: \_\_\_\_\_

If yes, did you experience any symptoms after the vaccine? \_\_\_\_\_

Are you taking medications for Shingles? YES NO If yes, list medications: \_\_\_\_\_

What, if anything, gives you relief: \_\_\_\_\_

Have you had any other treatments for Shingles? YES NO List Treatments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List traumas that you have had to the area in which you have symptoms: (falls, car accidents, sports injuries, broken bones, etc.)

\_\_\_\_\_  
\_\_\_\_\_

Has the area of shingles pain been the same or has it changed, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is there anything else you feel would be helpful for us to know?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Body Diagram

Please indicate all areas you are experiencing shingles/shingles symptoms.  
Fill in the area on the body diagram with the appropriate symbols below to describe your pain.

**Key:**

Stabbing: ///

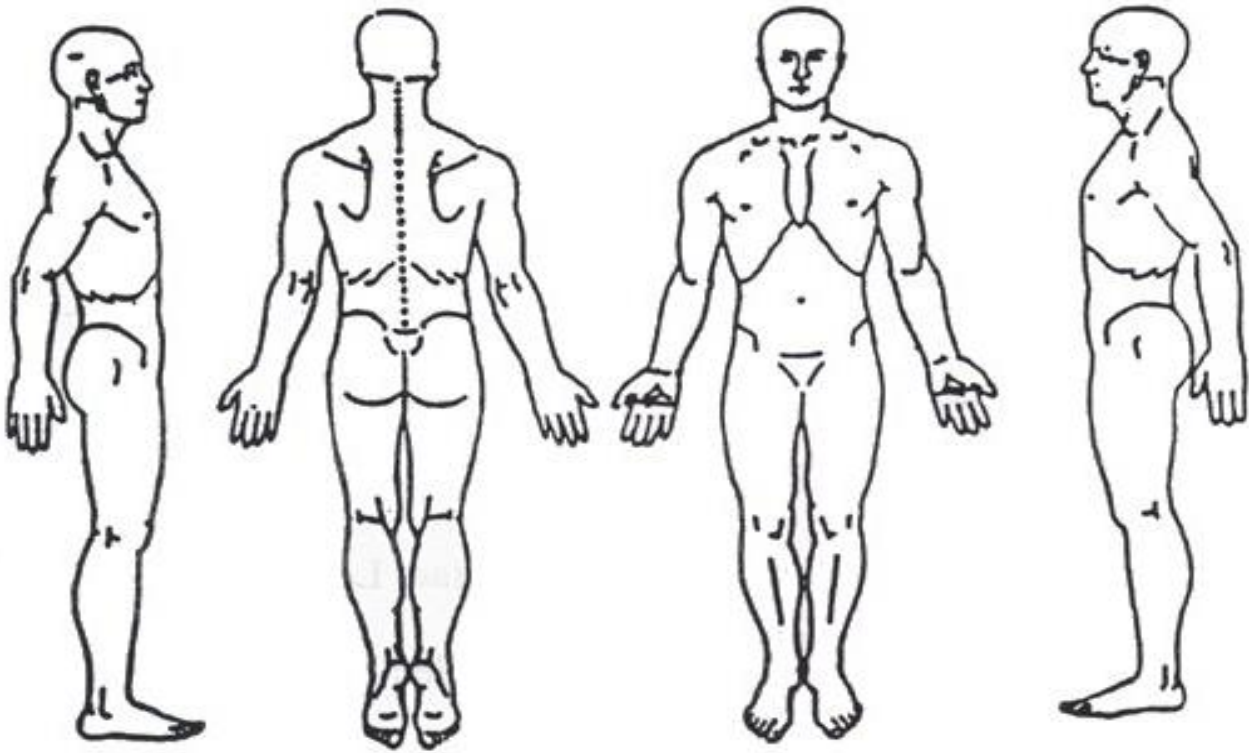
Burning: XXX

Pins and Needles: 000

Numbness: ===

Tingling: \*\*\*\*\*

Other: (●●●) \_\_\_\_\_



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## Visual Analogue Scale

Make a slash (/) along the line from the extremes, which you think represents your current pain/discomfort in your major area of injury.

No Pain at All

Pain as Bad As It Could Be

