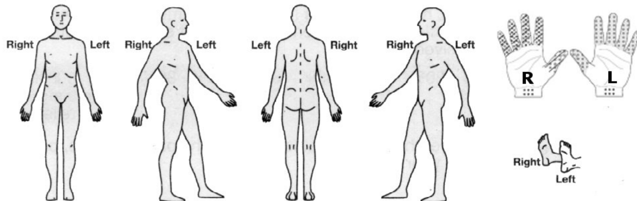
Patient Self Report

Name____________________________________**DOB**________________**Date**_______________

Where is your pain located?
(Please indicate below)



Pain frequency with treatment:
❑Occasional ❑Intermittent ❑Frequent ❑Constant

Pain description:
❑Dull ❑Aching ❑Throbbing ❑Cramping ❑Sharp
❑Burning ❑Shooting ❑Stabbing ❑Electrical

What makes your pain worse?
❑Sitting ❑Standing ❑Walking ❑Other___________

Pain ratings with treatment:

0 = No pain 10 = Pain as bad as it could be

Your pain level today:
0 1 2 3 4 5 6 7 8 9 10

Average during past month:
0 1 2 3 4 5 6 7 8 9 10

Worst during the past month:
0 1 2 3 4 5 6 7 8 9 10

Activities of daily living:

Physical Function
❑Better ❑Same ❑Worse

Mood
❑Better ❑Same ❑Worse

Relations with other people
❑Better ❑Same ❑Worse

Sleep Schedule
❑Better ❑Same ❑Worse

Overall Function
❑Better ❑Same ❑Worse

Adverse effects:

Constipation
❑None ❑Mild ❑Moderate ❑Severe

Urinary Hesitancy
❑None ❑Mild ❑Moderate ❑Severe

Nausea/ Vomiting
❑None ❑Mild ❑Moderate ❑Severe

Itching
❑None ❑Mild ❑Moderate ❑Severe

Sweating
❑None ❑Mild ❑Moderate ❑Severe

Drowsiness
❑None ❑Mild ❑Moderate ❑Severe

Mental Fogginess
❑None ❑Mild ❑Moderate ❑Severe

Do you have any NEW numbness?
❑No ❑Yes_______________________

Do you have any NEW muscle weakness?
❑No ❑Yes________________________

Have there been a major change in your bowel or bladder function such as bowel or bladder incontinence?
❑No ❑Yes________________________

How much relief did you receive from the last injection/procedure? (If one was done):
❑None ❑Some ❑Great ❑N/A

In general, what percentage of your pain is being relieved by your current treatment?__________________(0-100%)

Comments: __________________________
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