Interim Evaluation

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Name: _____ Date: _____

1- What would you like to discuss with the doctor today? (A) _____

(B) _____ (C) _____

2- **Pain impressions.** It is very helpful to your physician to have your description of your pain. We recognize this may be difficult to measure, but please do the best you can.

Rate your current pain by marking the 0 to 10 scale below.

0 = No Pain *10 = Extremely Intense*

0-----1-----2-----3-----4-----5-----6------7-----8-----9-----10

3- Are you attending physical therapy? _____ Therapist's Name _____

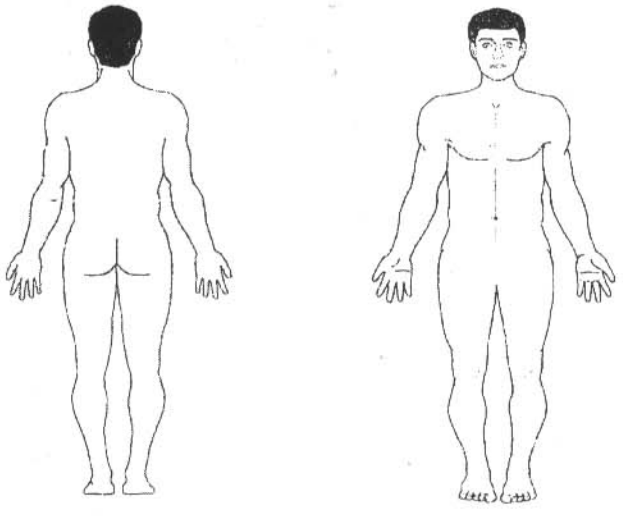
4- Are you presently working? _____ How many hours per day? _____

5- Please list your current medications:

Name	Dose	How Many / How Often
		/
		/
		/
		/

Using the symbols below, please mark all of the affected areas where you feel the described sensations.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
σ	— — —	O	X	/	●



Please note that several doctors work in each exam corridor and they see their patients in the order of their appointments. If a patient (who arrived after you) is called before you, they are not seeing your physician.