PAIN SHEET

****Completed by all Imaging patients except CT only procedures****

Last Name:	First Name:	Middle Init:	Date of Birth:

THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY

1. What was your chief complaint when you visited your doctor?_____

   _____

2. What do you think caused the problem?_____

   a. How long have you had this problem?_____

3. What does your doctor think is causing your problem?_____

4. Describe your pain and location, please be specific:

□ Dull □ Sharp □ Aching □ Other:_____

□ Front □ Back □ Inside □ Outside □ Other:_____

□ Right □ Left □ Shooting □ Down leg? □ Down Arm? _____

   a. Does anything make it better?_____

   b. Does anything make it worse?_____

5. Do you have any weakness? _____ Where?_____

6. Do you have any numbness?_____ Where?_____

7. Have you had surgery to the area being scanned today? □ Yes □ No

   a. When?_____

   b. What was done?_____

8. Have you ever broken any of your bones?_____

   a. Do you have arthritis in any of your joints? _____

9. Do you have any other medical conditions?_____

   a. History of cancer? _____

10. Describe your general health:_____

    a. Are you taking any medications?_____