



Please shade in where you have pain on the body diagrams:

Right Left Front

Left Right Back

Right Side

Left Side

Shade in/mark the areas of your pain distribution

Swedish Covenant Hospital  
Pain Assessment Scale

PATIENT NAME/  
I.D. STICKER:

DATE:

See Reverse As Well

What is your goal for therapy? \_\_\_\_\_

Have you had any of the following conditions? (Check all that apply)

<input type="checkbox"/> Heart attack/MI <input type="checkbox"/> Heart disease/surgery <input type="checkbox"/> Pacemaker <input type="checkbox"/> High cholesterol <input type="checkbox"/> High blood pressure <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumonia <input type="checkbox"/> Intubation <input type="checkbox"/> Diabetes <input type="checkbox"/> Peripheral neuropathy <input type="checkbox"/> Stroke (CVA) <input type="checkbox"/> Slurred speech <input type="checkbox"/> TIA <input type="checkbox"/> Swallowing difficulty <input type="checkbox"/> Circulation/vascular problems <input type="checkbox"/> Blood clot/DVT/Pulmonary embolism	<input type="checkbox"/> Arthritis <input type="checkbox"/> Broken bones/fractures <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Low back pain/sciatica <input type="checkbox"/> Bowel or bladder problems <input type="checkbox"/> Numbness and tingling <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Cancer <input type="checkbox"/> Significant weight loss <input type="checkbox"/> Infectious disease (e.g. tuberculosis, hepatitis, HIV) <input type="checkbox"/> Kidney problems <input type="checkbox"/> Liver disease <input type="checkbox"/> Depression <input type="checkbox"/> Mental illness <input type="checkbox"/> Eating disorder <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Hiatal hernia	<input type="checkbox"/> GERD <input type="checkbox"/> Stomach problems/ulcer <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Dementia <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Psychiatric disorders <input type="checkbox"/> Repeated infections <input type="checkbox"/> Seizures, Epilepsy <input type="checkbox"/> Skin diseases <input type="checkbox"/> Allergies <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Hearing impairment <input type="checkbox"/> Visual impairment <input type="checkbox"/> Other: _____
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Are you taking any medications?      YES              NO

Please list medications in space provided:

<b>Medications:</b>	<b>Start Date</b>	<b>Reason for taking</b>
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

**Surgical History**

<b>Procedure</b>	<b>Date</b>
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	