

BEFORE AND AFTER INJURY PAIN COMPARISON FORM

PATIENT: _____ DATE: _____

For **section 1** please describe on a scale of 1-10 in how intense your pain level was 2-3 months prior to this injury and indicate your current pain intensity. A zero indicates that no symptoms exists. A **1-3 pain** level is a minimum level and indicates that your pain is an annoyance only. A **4 pain** is a slight level or where pain doing activity begins to cause some disability. A **5-7 pain** is moderate in severity and has to restrict or limit your activity ability to a significant degree. A **8-10 pain** level is severe and indicates that your pain intensity is to point where you have complete inability to perform some tasks. For **section 2**, please relate the percentage of time you had pain 2-3 months prior to this injury and indicate your current status in a percentage. Please fill in (circle) all shaded areas that best apply to your case.

SECTION 1. PRIOR AND CURRENT PAIN INTENSITY LEVELS

First, **Circle the box once** following the area of pain that best indicates your overall average-usual pain severity before this injury. Secondly, **circle the box twice** that indicates your current usual pain intensity.

PAIN INTENSITY	None	Minimum			Slight-to-Moderate				Severe		
		Discomfort/Ache/Stiff			Hurts/Sore/Bearable Sensation				Sharp/Intense Pain		
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck Pain/Soreness	0	1	2	3	4	5	6	7	8	9	10
Arm/Hand Symptoms	0	1	2	3	4	5	6	7	8	9	10
Mid Back Pain	0	1	2	3	4	5	6	7	8	9	10
Low back Pain	0	1	2	3	4	5	6	7	8	9	10
Leg/Foot Symptoms	0	1	2	3	4	5	6	7	8	9	10

SECTION 2. PRIOR AND CURRENT PAIN FREQUENCY LEVELS

Circle the box once following the area of pain that best indicates what average percentage of time you had pain before this injury. Secondly, **circle the box twice** that indicates your current typical pain frequency.

PAIN FREQUENCY	None	Occasional			Intermittent			Frequent		Constant	
		Neck pain/soreness	0%	10%	20%	30%	40%	50%	60%	70%	80%
Arm/Hand Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid-back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low Back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg/Foot Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

HEADACHE AND/OR MIGRAINE FREQUENCY & DURATION

During the past week or since the accident/injury if applicable (if less than one week) indicate how frequent you had headaches and/or migraines. Be sure to indicate how many hours or days long each headache typically lasted.

How frequent did you have headaches 2-3 months before this injury?	_____ x week, _____ x month
How frequent do you have headaches currently?	_____ x week, _____ x month
How many hours or days did a typical headache last before this injury?	_____ Hours, _____ Days
How many hours or days do your typical headaches last currently?	_____ Hours, _____ Days
How many headache pills did you take prior to the accident typically?	_____ pills per month
How many headache pills do you take currently since the accident?	_____ pills per month