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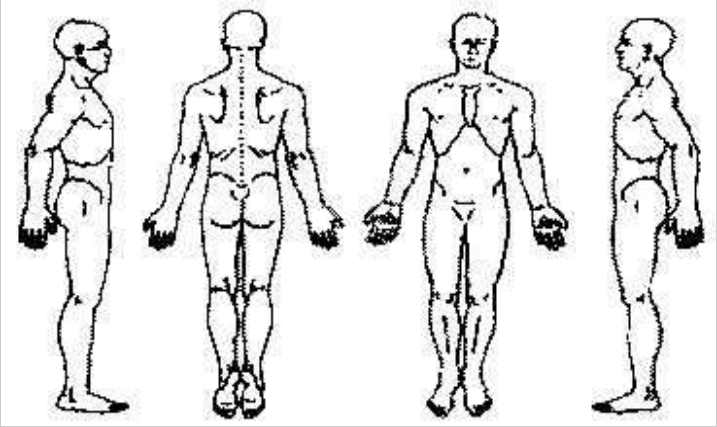
PATIENT HISTORY FORM B - OPTIONAL

Date: _____/_____/__ SSN (last 4 digits): xxx-xx-_____

Patient Name: _____

Shade the complaint areas(s) ☐ Does not apply



Place a vertical line across the scale below to indicate your level of pain. Do not use numbers. ☐ Does not apply

No Pain _____ Worst Possible Pain

Please rate your pain intensity, interference, distress, and sleep disturbance by using the scales below

A. Mark the line to indicate how much your pain has **interfered with your activities** this past week

None _____ Completely

B. Mark the line to indicate how much your pain has **interfered with your sleep** in the past week

None _____ The Most Imaginable

Patient Initials: _____