

PRE-PROCEDURE EVALUATION

Date: _____ Patient: _____

1. **Rate your back or neck** pain level **TODAY** on a 0-10 scale (0 no pain, 10 worst imaginable)

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

2. **What has been your last 3 DAY AVERAGE back or neck pain** on a 0-10 scale

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

3. **Rate your arm/shoulder or leg/buttock** pain level **TODAY** on a 0-10 scale

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

4. Please shade in where your pain is located, and place 'x' marks over areas of numbness.

