Patient Name:

TRUE MEDICAL IMAGING

Chart Number:

 

Front Right-Side Back Left-Side

**Use the appropriate symbol to show point of pain**

|  |  |  |  |
| --- | --- | --- | --- |
| Ache | AAAA | Pins and Needles | OOOO |
| Burning | XXXX | Stabbing | /////// |
| Numbness |  | Weakness | WWW |

How did injury/pain

occur?\_

\_

Where are you hurting? \_

\_

How long have these symptoms been present? \_\_

What is your pain level on a scale of a 1-10? (**10** being the worst **1** being the least)? \_ Please check one: Getting Better \_\_Getting Worse \_Staying Constant Intermittent

Have any surgeries or treatment been preformed for the current problem? \_ If so, when? \_\_

Tech Notes: \_

\_

\_ \_

Signature Date

\_ \_

Technologist Signature Date

100% Veteran Owned and Operated R 052216