Maximize Life Minimize Pain
PAIN SPECIALISTS OF GREATER CHICAGO

Please leave blank, to be filled in by office staff only

Today's Date: ____________________ Patient ID#: _________________

Provider: _________________________ Location: _________________

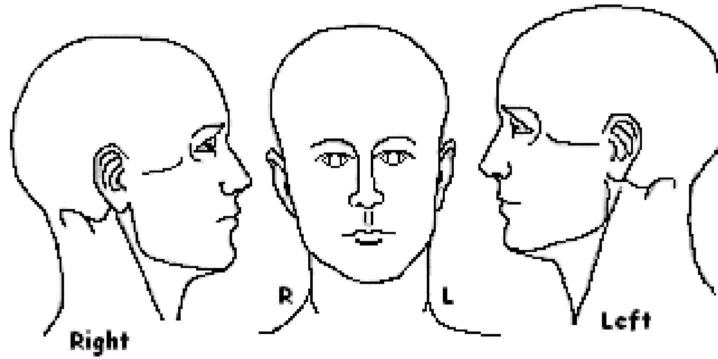
Pain Diagram

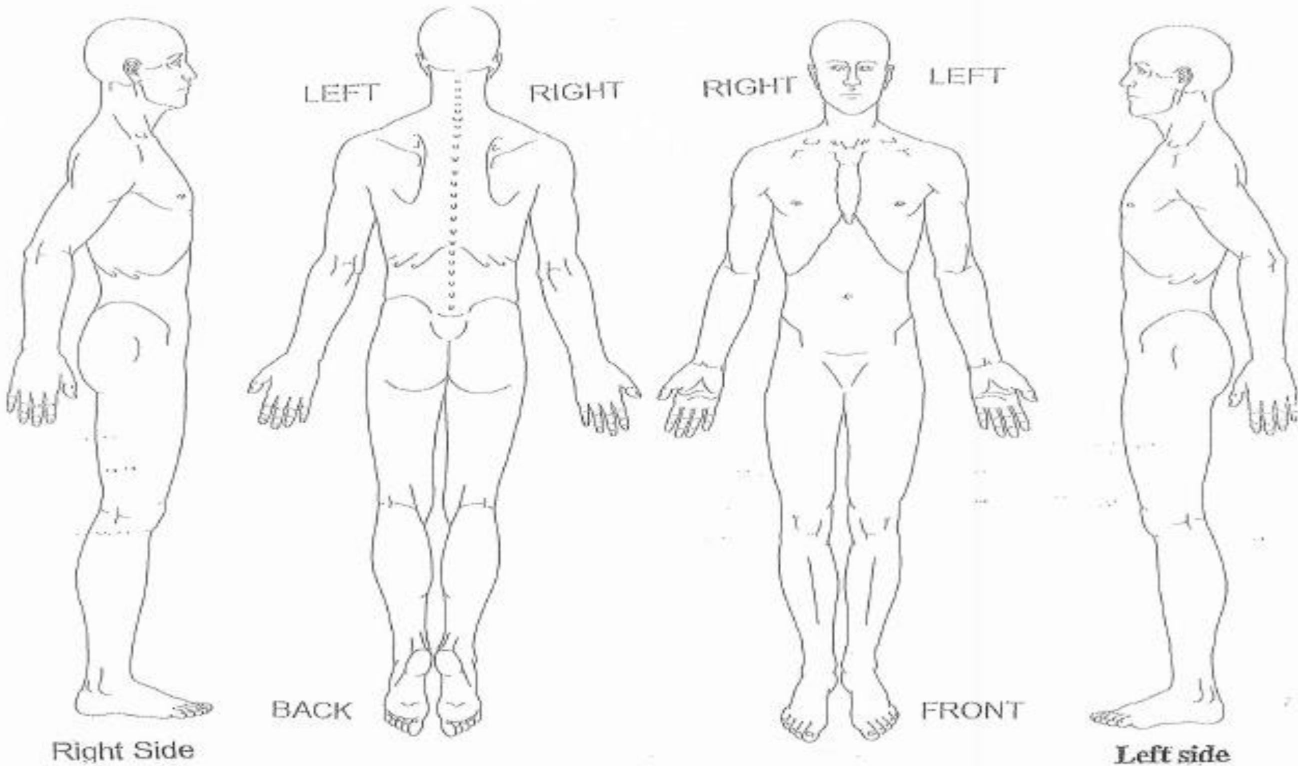
Patient Name (print): _____________________________________ Date of Birth: ___________________

1. Please identify on a scale of 0 to 10 your current pain score.

0	1	2	3	4	5	6	7	8	9	10	B/P
No Pain at all										Worst pain imaginable	P R

2. Please Shade *RED* for painful and burning areas then Shade *BLUE* for numb and tingling areas.





Please leave blank, to be filled in by office staff only

Today's Date: ___________________ Patient ID#: ________________

Provider: ________________________ Location: ________________

Disability Assessment

Patient Name (print): ____________________________________ Date of Birth: ___________________

Instructions: Circle the number that describes your current level of disability

0 = NO DISABILITY 10 = TOTAL DISABILITY

1. **Home Activities**: Includes active things you do around your home, including making bed, cooking, cleaning (dusting, vacuuming, dishes, laundry, and floors), shopping, yard work, etc.

   NO DISABILITY 0 1 2 3 4 5 6 7 8 9 10 TOTAL DISABILITY

2. **Passive, Recreational Activities**: Activities done alone or with others such as hobbies, puzzles, knitting, dining out, and going to movies, social functions (Does Not include, watching TV).

   NO DISABILITY 0 1 2 3 4 5 6 7 8 9 10 TOTAL DISABILITY

3. **Active, Physical Activities**: Activities done alone or with others that are sport or exercise in nature, such as long walks, jogging, swimming, bicycling, golfing, bowling, tennis, etc.

   NO DISABILITY 0 1 2 3 4 5 6 7 8 9 10 TOTAL DISABILITY

4. **Occupation and/or Education**: Includes physical and cognitive activities related to working your job, school, volunteer work, etc.

   NO DISABILITY 0 1 2 3 4 5 6 7 8 9 10 TOTAL DISABILITY

5. **Self-Care**: Including activities of daily living such as bathing, brushing your teeth, getting dressed, going to the bathroom, combing your hair, shaving, moving about your home, etc.

   NO DISABILITY 0 1 2 3 4 5 6 7 8 9 10 TOTAL DISABILITY

6. **Basic Life Activities**: Includes eating, drinking, and breathing.

   NO DISABILITY 0 1 2 3 4 5 6 7 8 9 10 TOTAL DISABILITY

7. **Sleep**: Includes your ability to fall asleep, stay asleep, and feel rested in the morning.

   NO DISABILITY 0 1 2 3 4 5 6 7 8 9 10 TOTAL DISABILITY

8. **Sexual Behavior**: Including the quality (frequency, ability, pleasure, etc.) of your sex.

   NO DISABILITY 0 1 2 3 4 5 6 7 8 9 10 TOTAL DISABILITY

9. **Thinking**: Refers to memory, attention, concentration, problem solving, understanding, etc.

   NO DISABILITY 0 1 2 3 4 5 6 7 8 9 10 TOTAL DISABILITY

10. **Social**: Refers to maintaining or developing relationships with family, friends, or others.

    NO DISABILITY 0 1 2 3 4 5 6 7 8 9 10 TOTAL DISABILITY