

Patient's Rating of Pain

Date _____

Patient Name _____

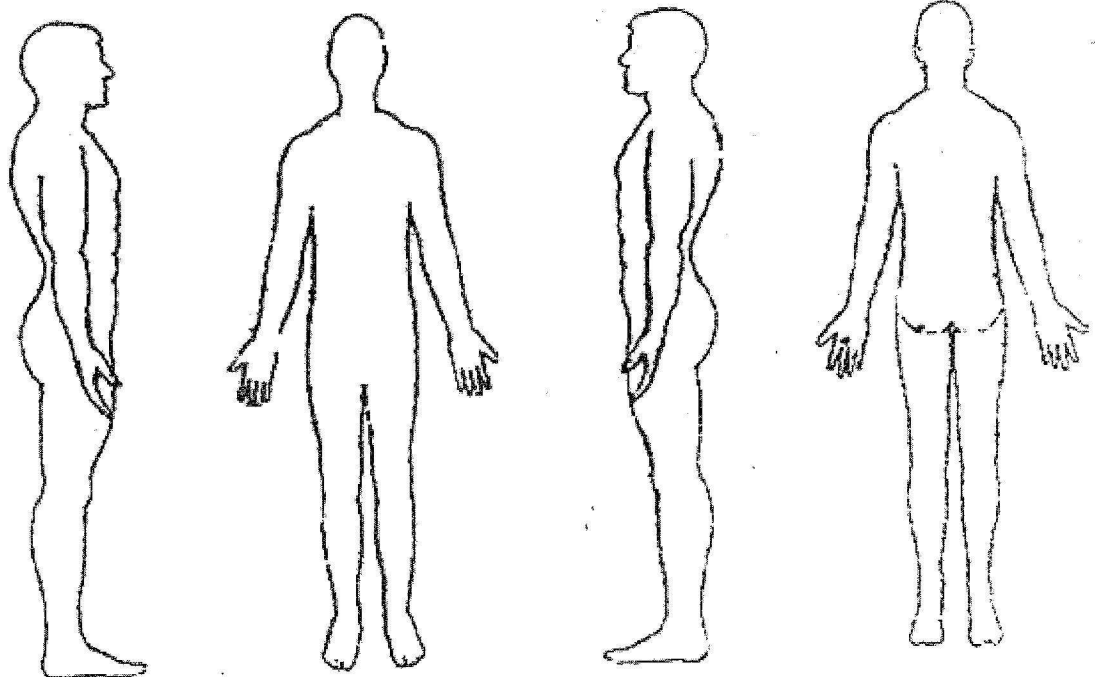
Patient # _____

Subjective Pain Level: On a scale of 1-10 place an X in your current pain level.

<u>Normal</u>	<u>Low Pain</u>	<u>Moderate Pain</u>	<u>Intense Pain</u>	<u>Emergency</u>
() 0	() 1	() 4	() 7	() 10
	() 2	() 5	() 8	
	() 3	() 6	() 9	

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark stress areas of radiation. Include all affected areas.

Pain Symbols			
Numbness	=====	Pins & Needles	+ + +
	=====		+ + +
Burning	X X X	Stabbing	/ / /
	X X X		/ / /



Coordination of Benefits

Main Policy

Insurance Company: _____ Policy Holder: _____
Health Plan: _____ Effective Date: _____
Birthdate: _____ SSN: _____
Through Employer? _____ Medicare or Medicaid? _____
Employer Name: _____ Insurance Company: _____
Coverage Type(s): Medical Vision Dental Other: _____
Family Members Covered: _____

Secondary Policy 1

Insurance Company: _____ Policy Holder: _____
Health Plan: _____ Effective Date: _____
Birthdate: _____ SSN: _____
Through Employer? _____ Medicare or Medicaid? _____
Employer Name: _____ Insurance Company: _____
Coverage Type(s): Medical Vision Dental Other: _____
Family Members Covered: _____

Secondary Policy 2

Insurance Company: _____ Policy Holder: _____
Health Plan: _____ Effective Date: _____
Birthdate: _____ SSN: _____
Through Employer? _____ Medicare or Medicaid? _____
Employer Name: _____ Insurance Company: _____
Coverage Type(s): Medical Vision Dental Other: _____
Family Members Covered: _____

Signature _____

Date _____