

# Buffalo Spine Surgery

Center for Excellence in Spine Care

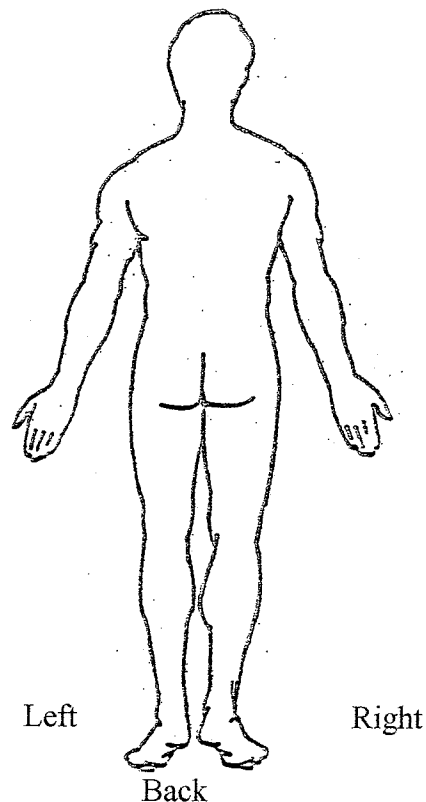
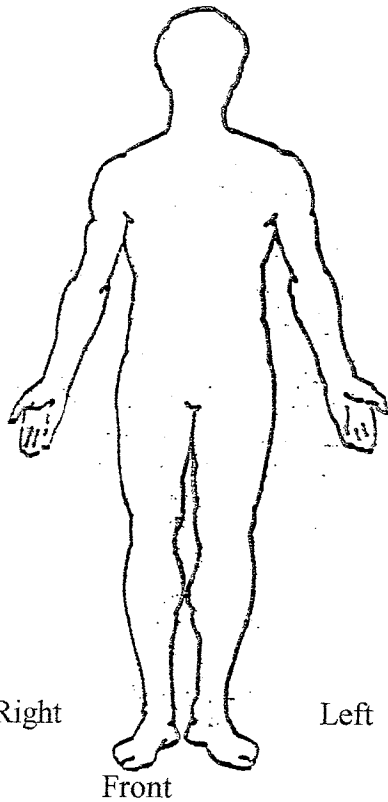
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NAME \_\_\_\_\_ DATE \_\_\_\_\_

Where is your pain now?  
Mark the areas where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas.  
To complete the picture please draw in your face.

Aching >>>>>      Numbness =====      Pins and Needles 000000000      Burning xxxx      Stabbing ////



How bad is your pain now?

Please mark an X on the body form where the pain is more severe now.

On a scale from 1-10 please mark on the line how bad your pain is now.

No Pain 0    Worst Possible Pain 10

0 \_\_\_\_\_ 10