

# TREATMENT AUTHORIZATION

I, \_\_\_\_\_, certify that the complaints listed below are true as related by me. I wish to be treated for these complaints and any additional complaints or problems, which may arise during the course of my treatment in this office today.

COMPLAINTS/	ACTIVITIES IMPAIRED DUE TO CONDITION
1.	/
2.	/
3.	/
4.	/
5.	/
6.	/

## VISUAL PAIN INTENSITY SCALE

What is your pain **RIGHT NOW**?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

What is your **TYPICAL or AVERAGE** pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

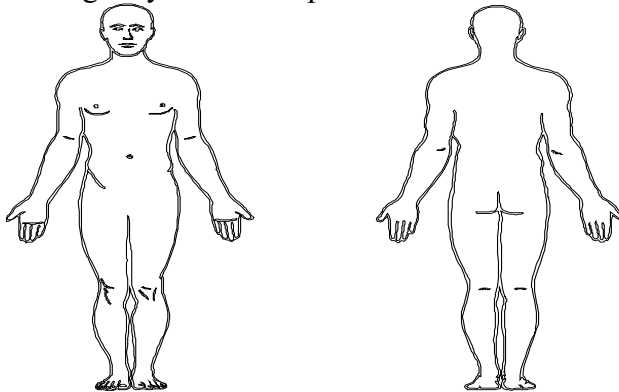
What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best)

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst)?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

Shade or mark on the figure your area of pain



Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Legal