Spinal Cord Stimulator Evaluation

Please complete ONLY IF you are seeing Dr. Shroff for a one time psychiatric evaluation for spinal cord stimulator.

Name: _____

Date: _____

0-10 Numeric Pain Intensity Scale

Please rate your average daily pain intensity on the scale:

	1	2	3	4	5	6	7	8	9	10	
No Pain	○	○	○	○	○	○	○	○	○	○	Worst

Somatic Symptom Scale - 8 (SSS-8)

During the past 7 days, how much have you been bothered by any of the following problems?

	Not at all	A little bit	Somewhat	Quite a bit	Very much
Stomach or bowel problems	0	1	2	3	4
Back pain	0	1	2	3	4
Pain in your arms, legs, or joints	0	1	2	3	4
Headaches	0	1	2	3	4
Chest pain or shortness of breath	0	1	2	3	4
Dizziness	0	1	2	3	4
Feeling tired or having low energy	0	1	2	3	4
Trouble sleeping	0	1	2	3	4