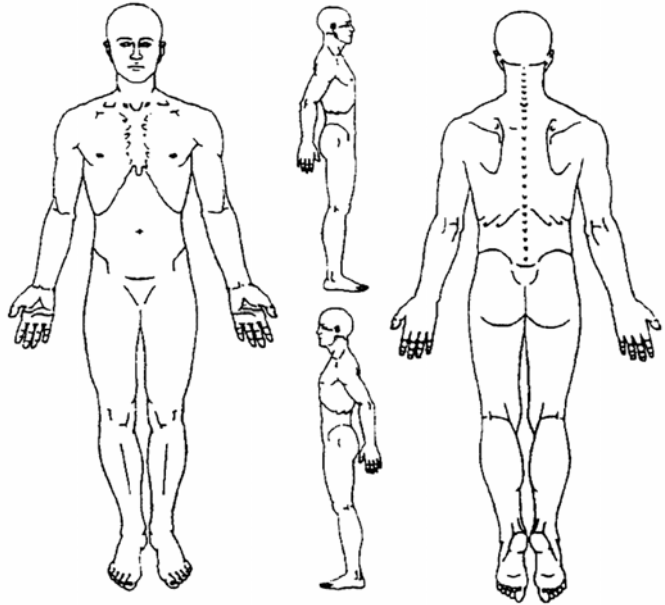


Pain Diagram and Rating

Please number and mark the **severity of pain** you are currently experiencing on a scale from 0 (no pain) to 10 (severe pain).

- Current pain: /10 0 1 2 3 4 5 6 7 8 9 10
 - Average pain: /10 0 1 2 3 4 5 6 7 8 9 10
- (Visual Analog Pain Severity Scale)

Please mark on the diagram the location of the pain.



Please describe the **type of pain** or sensation you are currently experiencing. (Check all that apply)

- | | |
|--|------------------------------------|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Other, describe it: _____ | |

- When did the pain begin? _____ Any flare-ups since then? If so, when? _____
- What brought the pain on? _____
- The pain is constant comes and goes. If it comes and goes, how often does the pain exist? _____
And for how long? _____
- Does it interfere with your Work Sleep Daily Routine Recreation Other _____
- Activities or movements that are painful to perform:
 Sitting Standing Walking Bending Lying Down None Other _____
- When and what makes it better? _____
- When and what makes it worse? _____
- Any prior injuries to the area of pain? _____
- Have you seen another healthcare practitioner for the pain/condition? Yes No
If yes, who? _____

Patient's Name _____ **Patient's Signature** _____ **Date** _____
PLEASE PRINT

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or is physically or legally incapacitated

Patient's Name _____ **Representative's Name** _____
PLEASE PRINT PLEASE PRINT

Representative's Signature _____ Relationship/Authority to Patient _____

Date Signed _____ Witness _____

Clinician's Name _____ **Clinician's Signature** _____ **Date** _____
PLEASE PRINT

