# 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

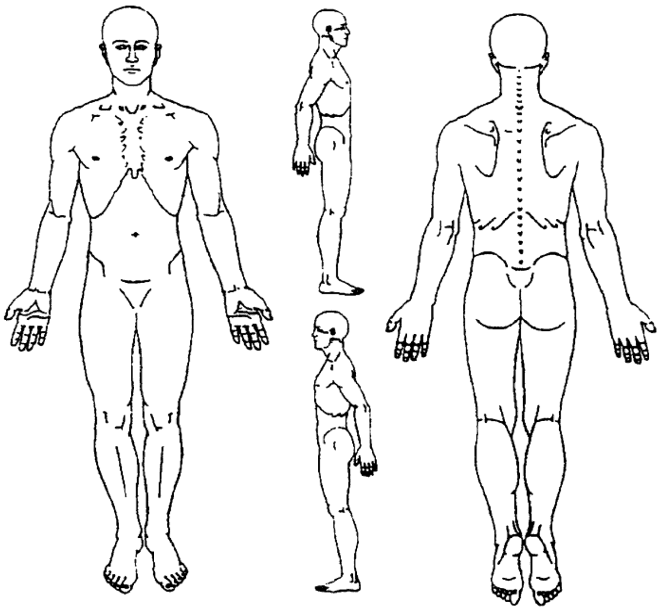
(Visual Analog Pain Severity Scale)

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

- ☐ Aching
- ☐ Burning
- ☐ Cramps
- ☐ Dull
- ☐ Numbness
- ☐ Sharp
- ☐ Shooting
- ☐ Stabbing
- ☐ Stiffness
- ☐ Swelling
- ☐ Throbbing
- ☐ Tingling

☐ Other, describe it: _____

Please mark on the diagram the location of the pain.



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 (PLEASE PRINT)** **Patient's or Responsible Party's Signature** **Date**

If signed by Responsible Party, please provide below information:

**Name (PLEASE PRINT)** **Relationship to patient** **Witness**

BELOW IS FOR OFFICE USE ONLY

**Clinician's Name (PRINT)** **Clinician's Signature** **Date**