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

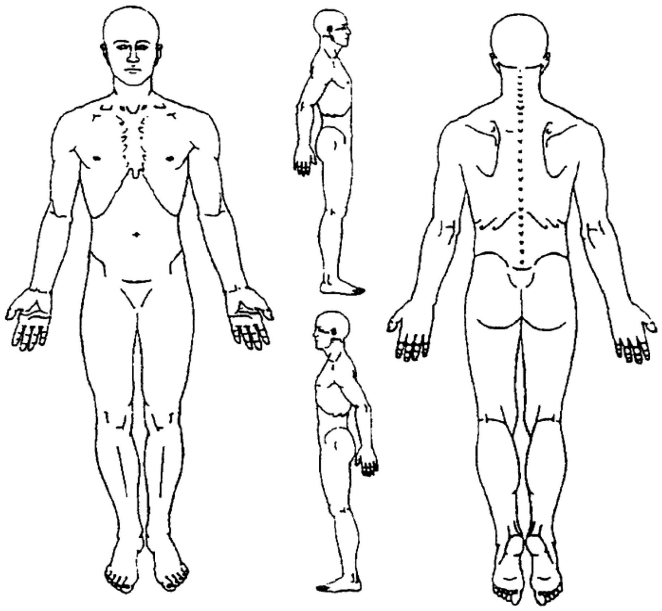
(Visual Analog Pain Severity Scale)

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**