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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).

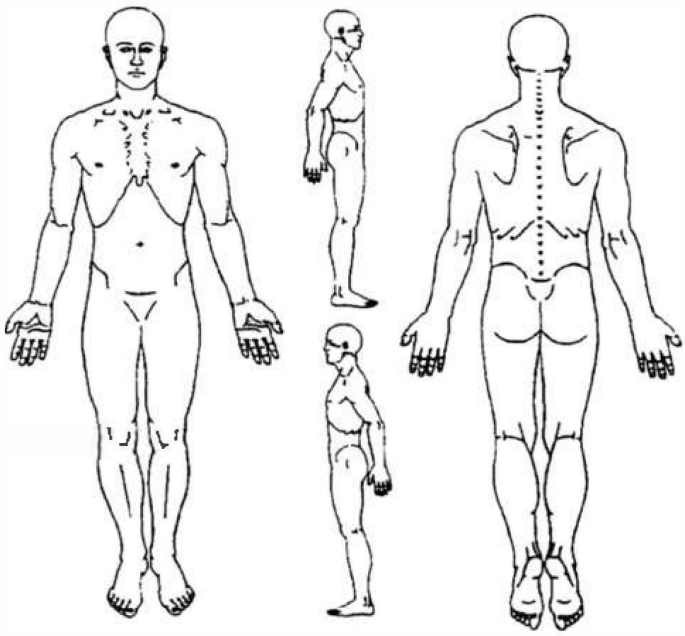
- Current pain: ___/10 0 1 2 3 4 5 6 7 8 9 10
- Average pain: ___/10 0 1 2 3 4 5 6 7 8 9 10

(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 Signature** _____ **Date** _____

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 _____ (PLEASE PRINT) **Representative's Name** _____ (PLEASE PRINT)

Representative's Signature _____ Relationship/Authority to Patient _____

Date Signed _____ Witness _____

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