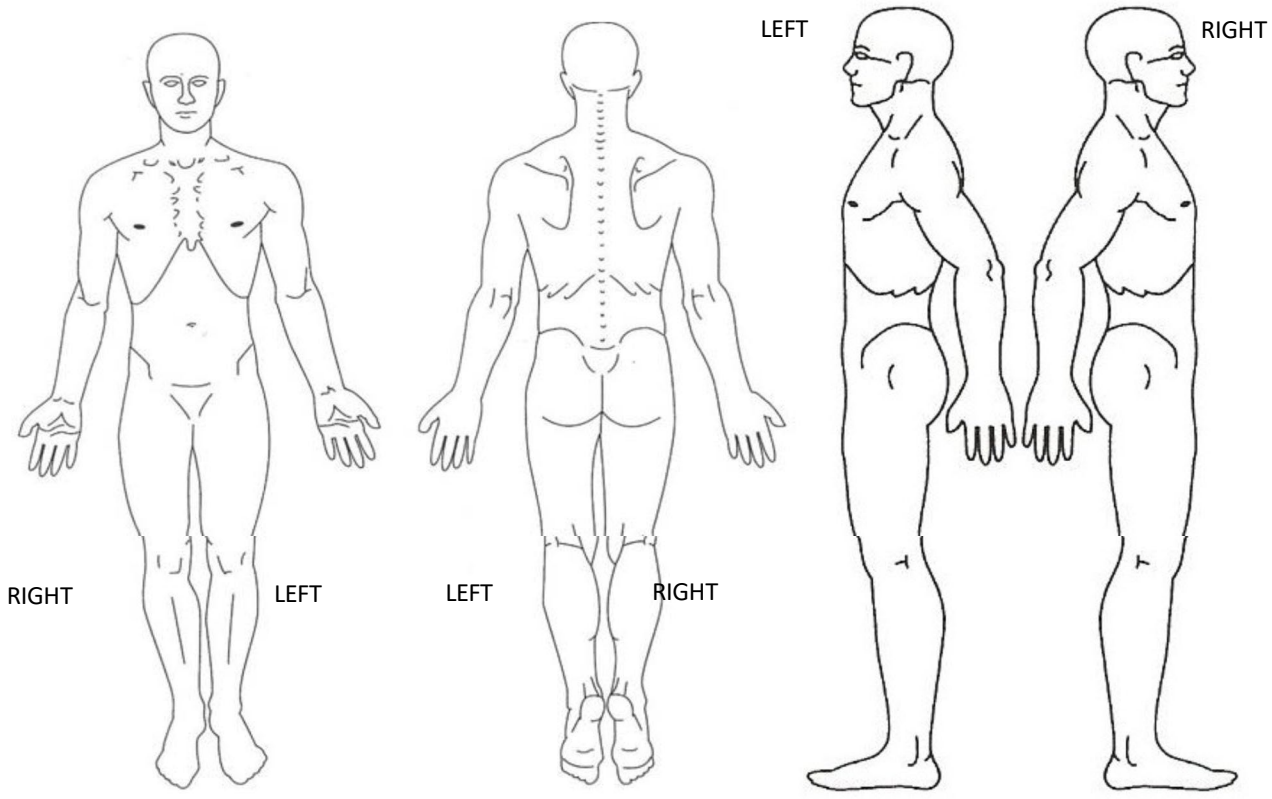
PATIENT NAME **DOB** **Age** **VISIT DATE**

PAIN DIAGRAM

Please mark **WHERE** you feel pain.
Mark the areas on your body where you feel the sensations described below, using the appropriate symbols.
Mark the areas of radiation. Included **ALL** affected areas.

ACHING	^ ^ ^ ^	BURNING	X X X X	PINS and NEEDLES	O O O O
NUMBNESS	= = = =	STABBING	/ / / /		



How bad is your pain now? _____

Please mark with an X on the BODY diagram ***above*** where your pain is the worst now.

Please CIRCLE number on the line ***below*** how BAD your pain is now for each area.

1 2 3 4 5 6 7 8 9 10 NECK PAIN

1 2 3 4 5 6 7 8 9 10 UPPER BACK PAIN

1 2 3 4 5 6 7 8 9 10 LOW BACK PAIN

No Pain Worst Possible Pain