

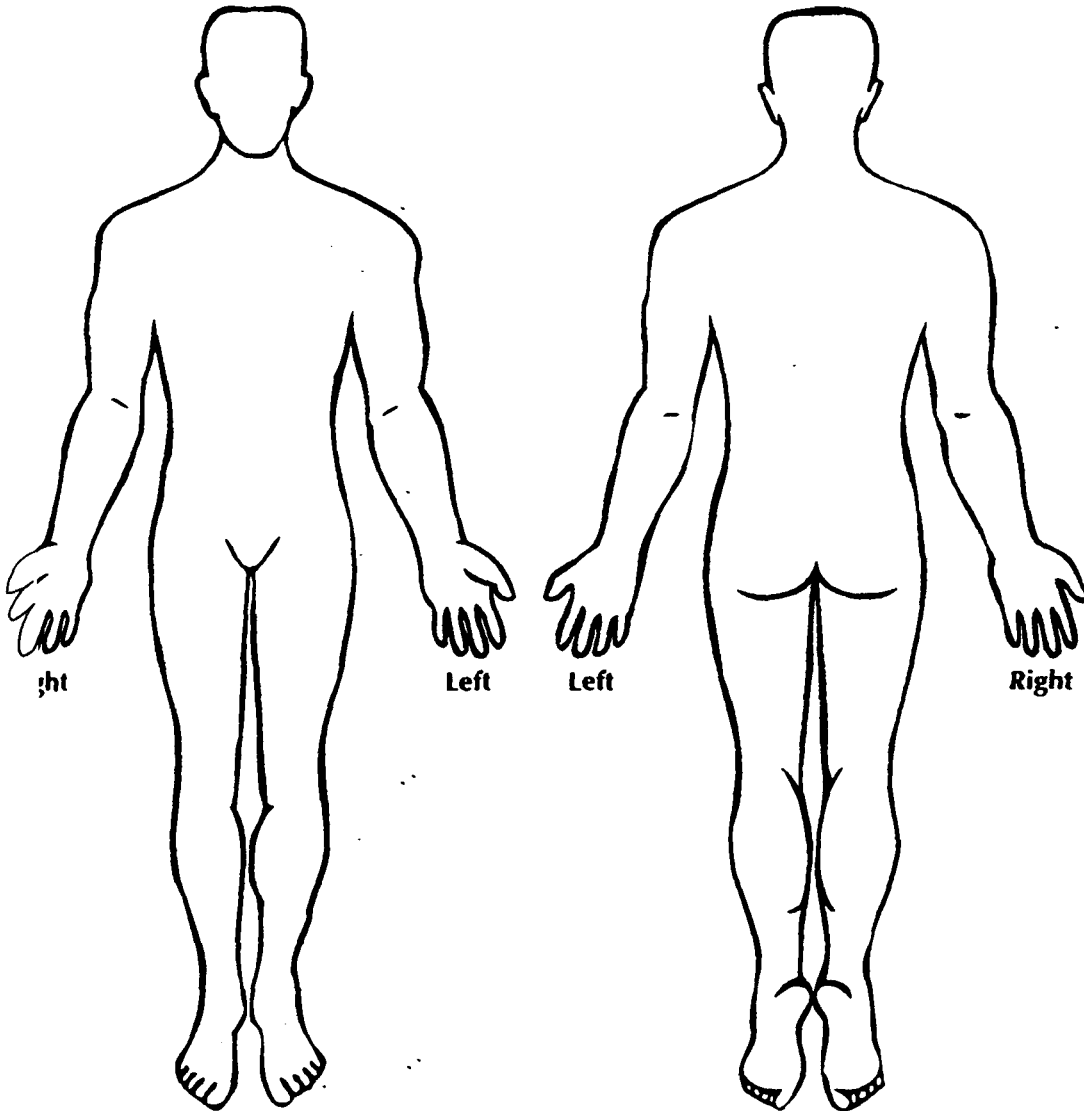
PAIN DRAWING

Name _____ Date _____

Be sure to fill this out as accurately as you can. Mark the area(s) on your body where you feel the described sensation. Use the appropriate symbol. Mark any areas of radiation. Include all affected areas.

FRONT

BACK



Symbols

Numbness: **=====**

Pins & Needles: **oooooooo**

Burning Pain: **xxxxxxx**

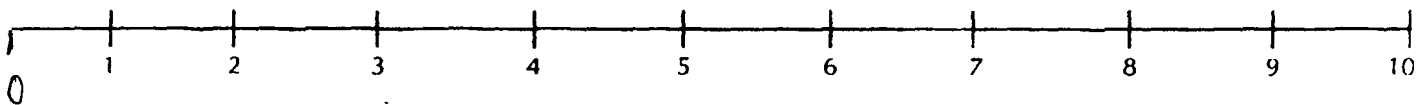
Stabbing Pain: **////////**

Aching Pain: **(((((((**

On a scale of 1 to 10, please indicate with an "X" the level of pain you are experiencing right now:

(Least Intense)

(Most Intense)



Indicate the frequency at which you experience this level of pain:

Rarely
 Once a month
 Once a week
 Once a day
 More than once a day
 Constant pain