

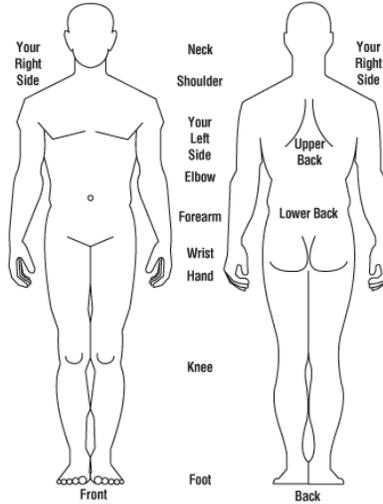
Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please mark the area of injury or discomfort on the chart below, utilizing the appropriate symbols:

Pins & Needles: 0000    Burning: XXXX    Stabbing: ////

Shooting: \*\*\*\*    Aching: ZZZZ



**OFFICE USE ONLY**

HT: \_\_\_\_\_

WT: \_\_\_\_\_

TE: \_\_\_\_\_

0=NO PAIN

10=EXTREMELY INTENSE PAIN

Pain right now:    0 1 2 3 4 5 6 7 8 9 10

Worst pain:        0 1 2 3 4 5 6 7 8 9 10

Best pain:         0 1 2 3 4 5 6 7 8 9 10

**Present symptoms: I would describe my pain as:**

- |                                   |                                    |                                   |  |
|-----------------------------------|------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Ache     | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Sharp    | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Soreness | <input type="checkbox"/> Shooting  | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Burning           |
| <input type="checkbox"/> Spasms   | <input type="checkbox"/> Other     |                                   |  |

**My pain occurs:**

- |  |   |
|--|---|
| <input type="checkbox"/> Intermittently (comes and goes) | <input type="checkbox"/> Once per day   |
| <input type="checkbox"/> Constantly (never goes away)    | <input type="checkbox"/> Once per week  |
| <input type="checkbox"/> Other                           | <input type="checkbox"/> Once per month |

**My pain is better with:**

- |                                  |                                     |                                   |   |
|----------------------------------|-------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Rest    | <input type="checkbox"/> Medication | <input type="checkbox"/> Exercise | <input type="checkbox"/> Change in position |
| <input type="checkbox"/> Heat    | <input type="checkbox"/> Ice        | <input type="checkbox"/> Standing | <input type="checkbox"/> Walking            |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Other      |                                   |   |

**My pain is worse with:**

- |                                       |  |  |   |
|---------------------------------------|--|--|---|
| <input type="checkbox"/> Lifting      | <input type="checkbox"/> Bending         | <input type="checkbox"/> Standing          | <input type="checkbox"/> Walking            |
| <input type="checkbox"/> Sitting      | <input type="checkbox"/> Climbing stairs | <input type="checkbox"/> Coughing/Sneezing | <input type="checkbox"/> Sexual intercourse |
| <input type="checkbox"/> Worry/stress | <input type="checkbox"/> Other           |  |   |