PRIMECARE CONSULTING, LLC

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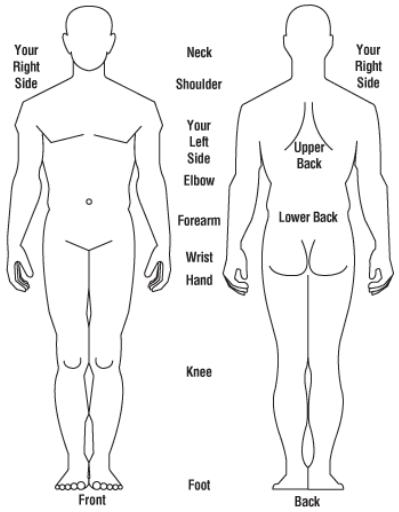
Name:_____ Date:_____

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:_____

BP:_____

HR:_____

_____

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:

____Ache ____Stiffness ____Sharp ____Numbness/Tingling
____Soreness ____Shooting ____Stabbing ____Burning
____Spasms ____Other

My pain occurs:

____Intermittently (comes and goes) ____Once per day
____Constantly (never goes away) ____Once per week
____Other ____Once per month

My pain is better with:

____Rest ____Medication ____Exercise ____Change in position
____Heat ____Ice ____Standing ____Walking
____Sitting ____ Other

My pain is worse with:

____Lifting ____Bending ____Standing ____Walking
____Sitting ____Climbing stairs ____Coughing/Sneezing ____Sexual intercourse
____ Worry/stress ____Other