

PAIN RATING & DRAWING

PATIENT NAME _____

DATE _____

HOW LONG HAVE YOU HAD THIS PAIN? _____

WITHIN THE LAST COUPLE OF DAYS TO A WEEK PLEASE RATE YOUR LEVEL OF PAIN AND FREQUENCIES.

Pain Levels: Using a 0 - 10 Pain Scale (0 = No pain, 10 = Most intense pain imaginable)

Rate your current level of pain _____, percent of time at this level of pain _____%.

Rate your average pain level _____, percent of time at this level of pain _____%.

Rate the worst your pain gets _____, percent of time at this level of pain _____%.

Rate the lowest your pain gets _____, percent of time at this level of pain _____%.

What things are you unable to do or must modify to perform? _____

What will bring on or intensify your pain? _____

KEY

USE LETTERS BELOW TO INDICATE TYPE AND LOCATION OF DISCOMFORT

A = ACHE	B = BURNING	C = STABBING
N = NUMBING	P = PINS & NEEDLES	O = OTHER

