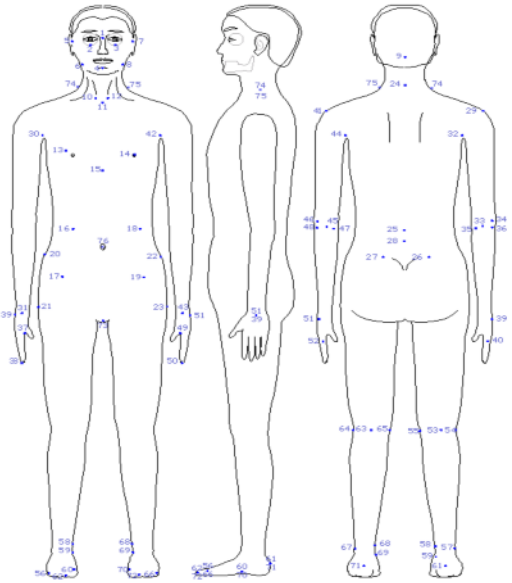
Diagrams

- Place a **circle** where you feel pain.

- Draw an **arrow** from the circle if the pain travels to other parts of the body.

- Place **X's** at any areas of numbness or tingling.



Pain Evaluation

Rate the severity of your pain. (1 to 10: mild to severe)

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Symptoms

Primary Complaint:	Date of Onset:	Circumstances of Onset:
Type of Pain: **(Please Circle at Right)**	Sharp Dull Throbbing Numbness Aching Shooting	Burning Tingling Cramps Stiffness Swelling Other
How often does it bother you?	Constant:ly Specific Tme of Day Specific Tme of Night	Weekly Monthly Seasonally
Which activities are difficult to perform?	Sitting Walking Standing Bending	Lying Down Changing Position Other
What eases the pain?	Hot Packs Cold Packs	Medication (Specify) Other
Have you experienced the same pain previously?	Yes No	If Yes, When?
Did you require emergency room care?	Yes No	If Yes, When?
List health care providers seen for this condition:	Names: Date: - - - - - -	Diagnosis: - - -
List any medications that you are currently taking:		
Did your complaint require hospitalisation?	Yes No	If Yes, When?