

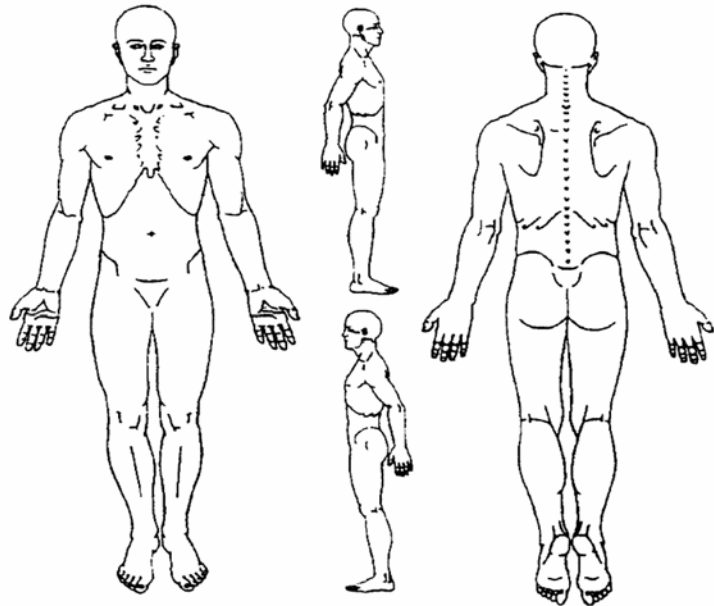
# Pain Diagram and Rating

If you are here to seek pain management, please mark on the diagram the type and location of the pain.

## TYPE OF PAIN YOU ARE CURRENTLY EXPERIENCING...

Place appropriate symbol or letter on the diagram.

- Ache = A A A A A
  - Burning = X X X X X
  - Cramps = C C C C C
  - Dull = O O O O O O
  - Numbness = N N N N N
  - Sharp = s s s s s s s s
  - Shooting = <<<<<<<<<<
  - Stabbing = / / / / /
  - Throbbing = - - - - -
  - Tingling = + + + + + + + +
  - Other Sensation = #####
- (Describe it: \_\_\_\_\_)



## VISUAL ANALOG PAIN SEVERITY SCALE

- Please place a mark on the line that corresponds to your **current** pain.

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN EVER

- Please place a mark on the line that corresponds to your **average** pain.

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN EVER

- When did the pain begin? \_\_\_\_\_ Any flare-ups since then? If so, when? \_\_\_\_\_
- What brought the pain on? \_\_\_\_\_
- What makes the pain better? \_\_\_\_\_
- What makes it worse? \_\_\_\_\_
- How often does the pain exist? \_\_\_\_\_ And for how long? \_\_\_\_\_
- Any prior injuries to the area of pain? \_\_\_\_\_
- Have you seen another healthcare practitioner for the pain/condition? Yes / No  
If yes, who? \_\_\_\_\_

**Patient's Name** \_\_\_\_\_ **Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
PLEASE PRINT

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or is physically or legally incapacitated

**Patient's Name** \_\_\_\_\_ **Representative's Name** \_\_\_\_\_  
PLEASE PRINT PLEASE PRINT

**Representative's Signature** \_\_\_\_\_ Relationship/Authority to Patient \_\_\_\_\_

**Date Signed** \_\_\_\_\_ Witness \_\_\_\_\_

**Clinician's Name** \_\_\_\_\_ **Clinician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
PLEASE PRINT