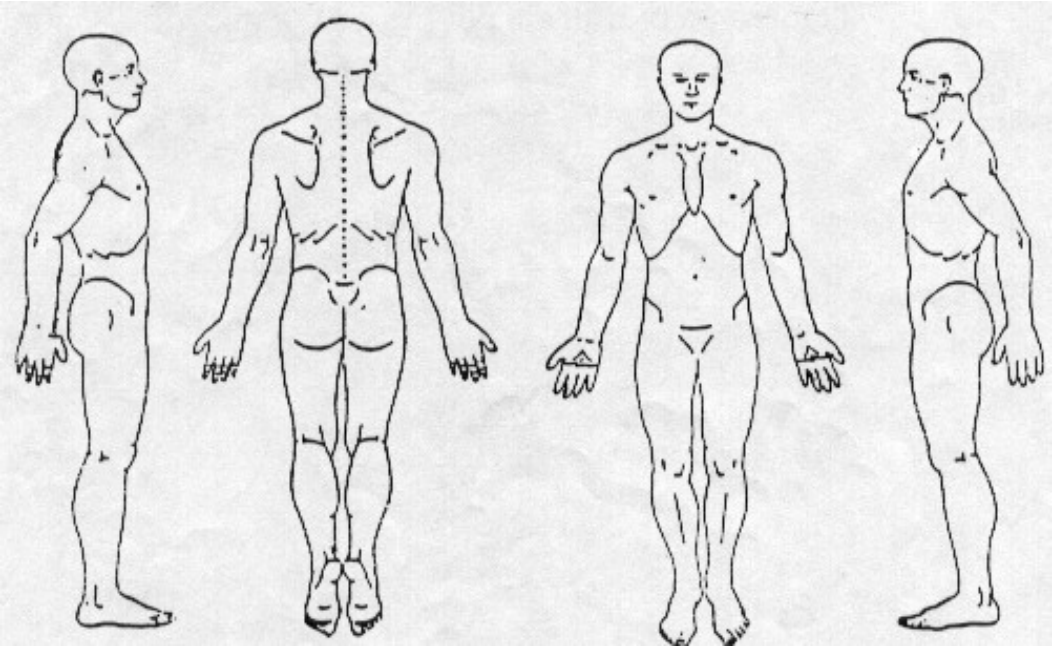
Pain Diagram

Name_____Today's Date_____Date of Birth___/____/____
Date that your symptoms became worse: ___/____/____
What action(s) may have caused your symptoms_____
_____
What have you done to treat your symptoms_____
_____
On the diagram below, please indicate where you are experiencing pain or other symptoms right now. Please use the numbers from the key below to represent what you feel.



1. Dull	2. Sharp	3. Throb	4. Burn	5. Ache	6. Tingle	7. Cramp	8. Numb	9. Stiff

Please mark the below line with the severity of your discomfort **right now**.

0	1	2	3	4	5	6	7	8	9	10
no pain		mild				moderate				severe pain

Please circle the items that describe your condition.

These aggravate my condition: sit / stand / walk / bend / stoop / lift / sleep / sneeze / cough / reach / twist / look up / look down / movement / rest / typing / house chores / exercise / stairs / lying down

These relieve my condition: sit / stand / lying down / knees up / bracing / movement / no movement / heat / ice / analgesic cream / ibuprofen / medicine / rest / stretch / exercise

_____
Patient Signature