File #_____

Patient::_____ DATE:_____

Patient Signature:_____

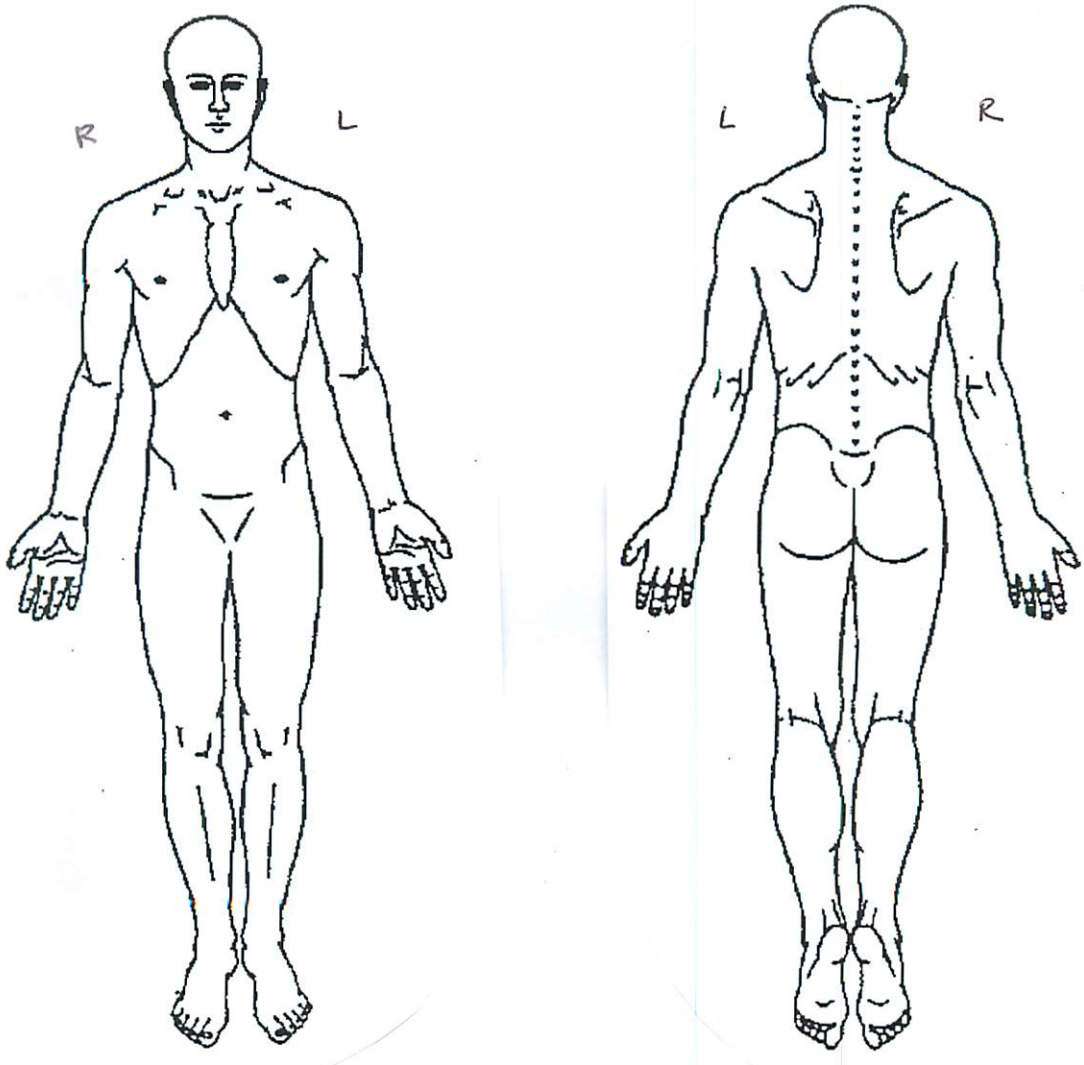
PAIN DIAGRAM

1) **Circle a Number or numbers** that describes the intensity of what you are feeling.
2) **Place a Letter** on the areas of the body where you are experiencing the symptom(s).

0	1	2	3	4	5	6	7	8	9	10

No Pain — Mild Pain → Moderate Pain → Severe Pain →

PAIN (P)
TINGLING (T)
NUMBNESS (N)
BURNING (B)
STIFFNESS (S)



Please explain what affect this has had on your Activities of Daily Living (eating, dressing, personal hygiene, getting in and out of bed, sleeping, working, playing, etc.): _____