Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximately how long have you had this pain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this your first episode of this pain? \_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_ No

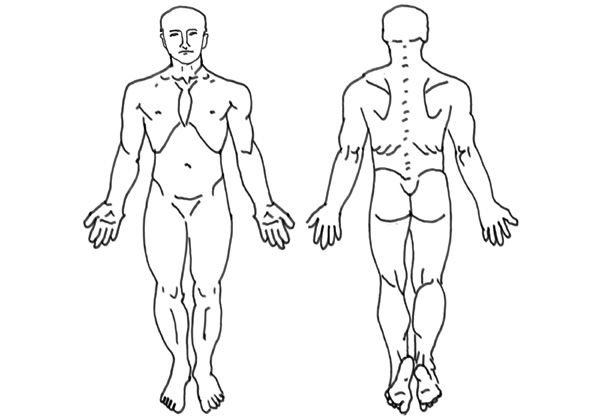
Is the pain- \_\_\_\_\_\_ Continuous or \_\_\_\_\_\_ Intermittent?

When is your pain worst? \_\_\_Morning \_\_\_ Daytime \_\_\_ Night \_\_\_ Random

**Please mark on the following body diagram the location and type of pain you are currently having using the following letters:**

**N- Numbness S- Stabbing/ Sharp A- Ache**

**B- Burning P- Pins and Needles**



**Please rate your current pain level by circling the appropriate number:**

**0 1 2 3 4 5 6 7 8 9 10**

**NO PAIN HIGHEST PAIN**