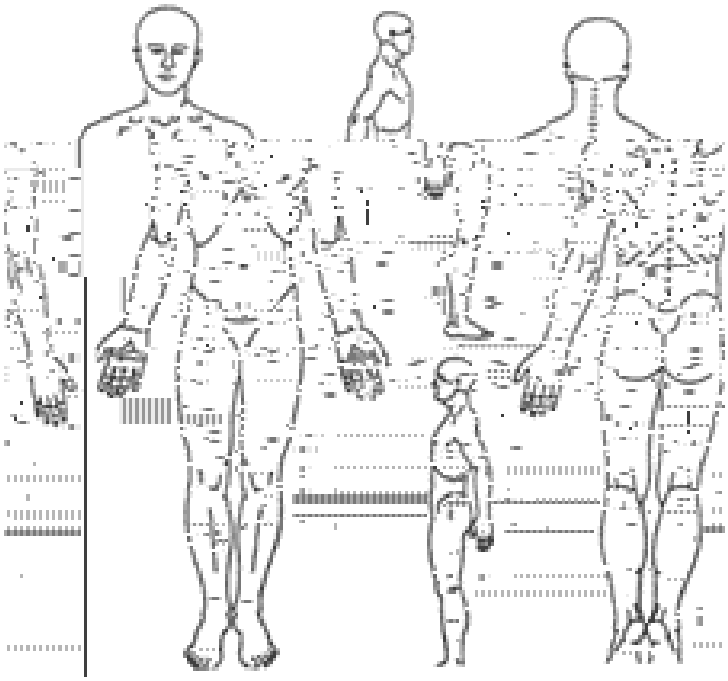
Date: ___/___/___ Patient Name: _____

Physical/Occupational/

Pain

Mark your pain locations on the diagram



Pain Rating
Scale used 0-10 (0=no pain, 10=emergency room pain)

Please Circle Number
Pain at rest 0 1 2 3 4 5 6 7 8 9 10
Pain with activity 0 1 2 3 4 5 6 7 8 9 10

Description of Pain:
Ã Sharp Ã Dull Ã Burning Ã Electrical Ã Cramping
Ã Pain is localized Ã Pain is radiating

What make your pain worse?
Ã Sitting Ã Standing Ã Walking Ã Twisting

Ã Bending ÃSquatting Ã Time of the day

Ã Running Ã Climbing Stairs Ã Physical Activity

Ã Weather Ã Lifting floor to waist