Name:_____ Date of Birth_____ Today's Date:_____

PAIN RATING

10+ MAXIMAL
10 VERY, VERY STRONG
9
8
7 VERY STRONG
6
5 STRONG
4 SOMEWHAT STRONG
3
2 WEAK
1 VERY WEAK
0.5 VERY, VERY WEAK
0 NOTHING AT ALL

Using the numbers above, please rate your major area of pain on the 0-10 pain rating scale by writing below the number of your pain at the present time, at its best and worst and average over the past 10 days.

_____ NOW _____ BEST _____ WORST _____ AVERAGE

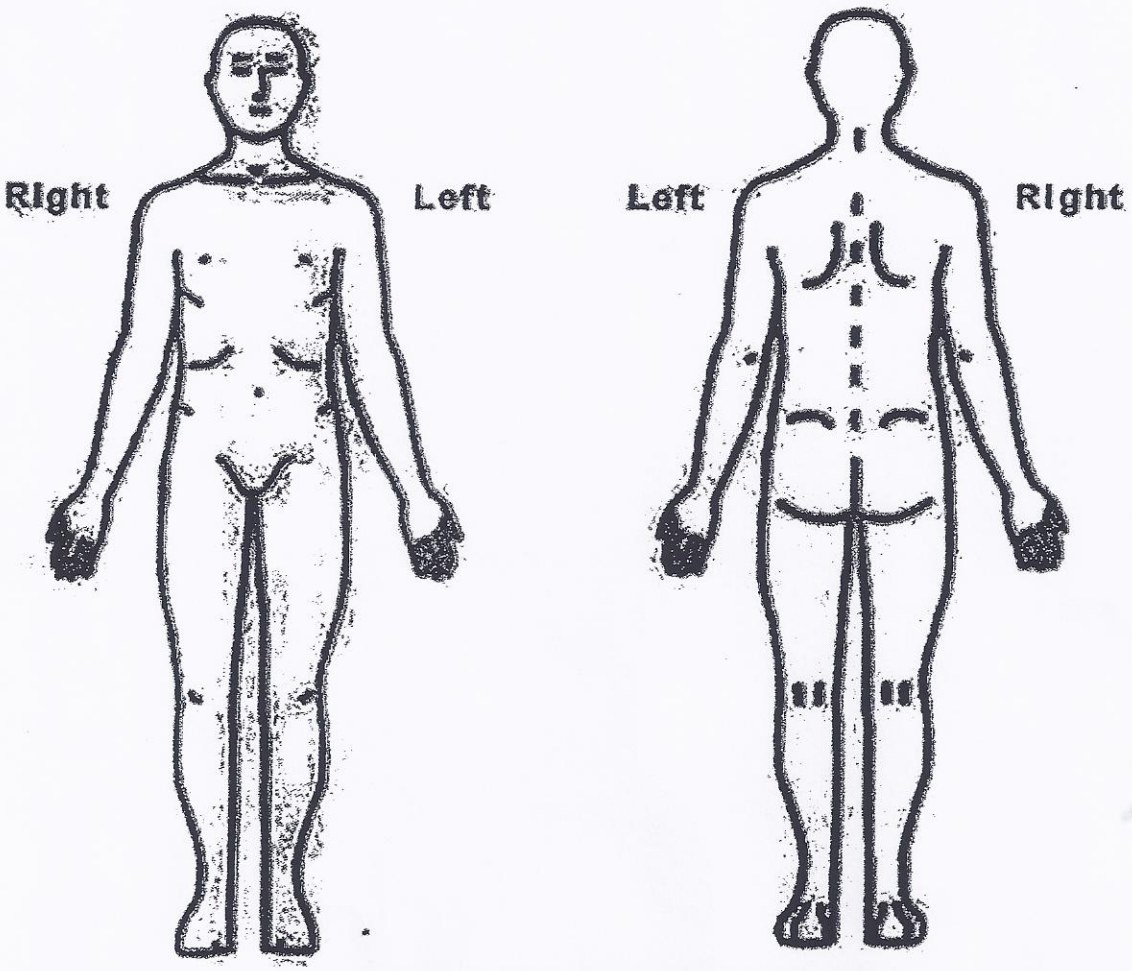
Do you experience any of the following?

_____NUMBNESS _____TINGLING

_____SHARP OR STABBING PAIN _____DULL OR ACHING

_____BURNING _____DISCOMFORT OR CRACKING

Please mark the body diagram below with X's anywhere you are experiencing pain:



PLEASE COMPLETE ENTIRE FORM