



PATIENT PAIN CHART

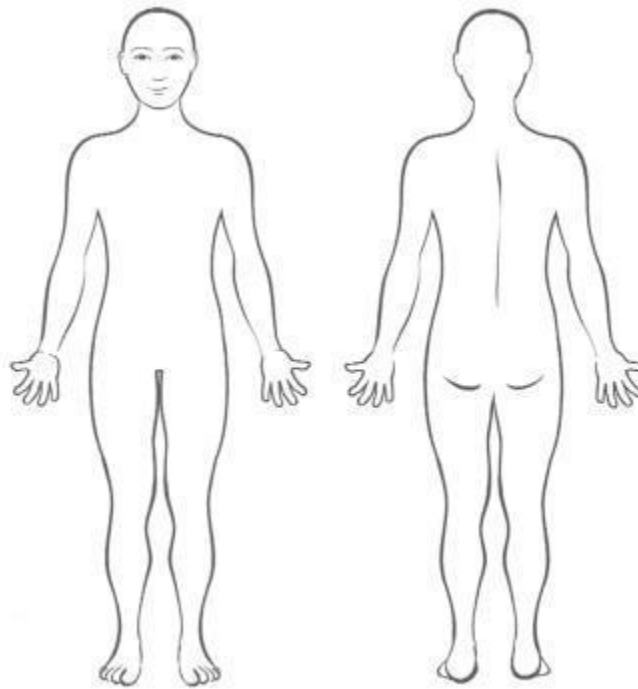
PATIENT NAME: _____ DATE: _____

Weight: _____ lbs Height: _____ ft. _____ in

Please describe your condition:

Mark the areas on the body where you feel the described sensations.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	OOOOO	^^^	XXX	●●●●



(right) FRONT (left) (left) BACK (right)

The line below represents the intensity of your pain. Please mark an "X" at the position on the scale which indicates how much pain you feel at this time.

No pain Worst Pain Imaginable

Signature: _____