PATIENT PAIN CHART

PATIENT NAME: ________________________________ DATE: ____________

Weight: ___________ lbs Height: __________ ft. __________ in

Please describe your condition:

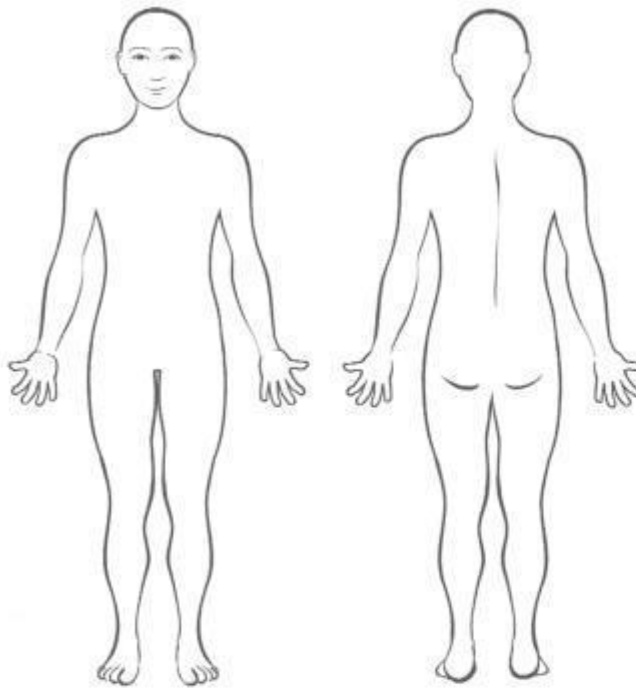
____

____

____

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: ____