

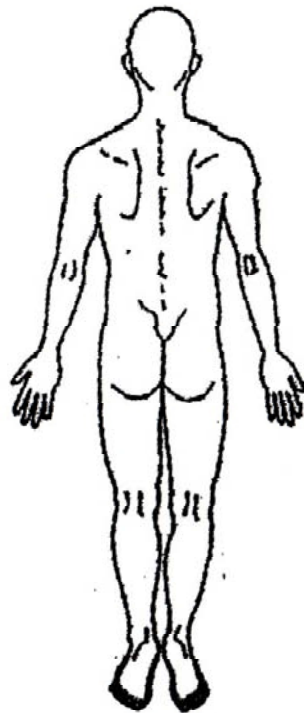
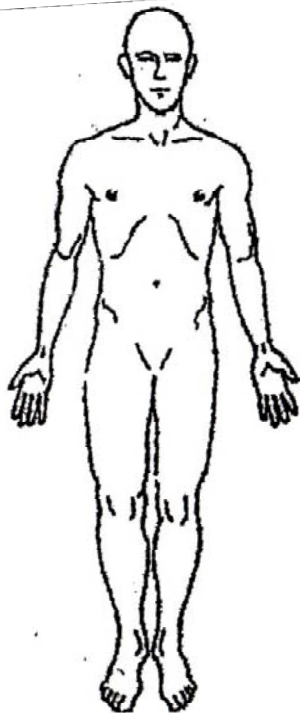
PAIN DRAWING

Name _____ Date _____

Date of Birth _____ Dr. _____

Ache <<<< Numbness Pins & Needles ooooo
 <<<< ooooo

Burning XXXX Stabbing ///// Throbbing ~~~~~
 XXXX ///// ~~~~~



SYMPTOM RATING SCALE

Symptoms often vary in intensity. Please answer these questions about your CURRENT symptoms.

1. What is your symptom intensity **RIGHT NOW**?

0	1	2	3	4	5	6	7	8	9	10
No symptoms						Unbearable Symptoms				

2. What is your **TYPICAL or AVERAGE** symptom intensity?

0	1	2	3	4	5	6	7	8	9	10
No symptoms						Unbearable Symptoms				

3. What is your symptom intensity at its **WORST**?

0	1	2	3	4	5	6	7	8	9	10
No symptoms						Unbearable Symptoms				

4. How often are your symptoms present? _____%

5. What are you concerned about today? _____

Additional comments or questions: _____
