PAIN DRAWING

Name: _____ **DOB:** _____

Ache	Numbness	Pins & Needles
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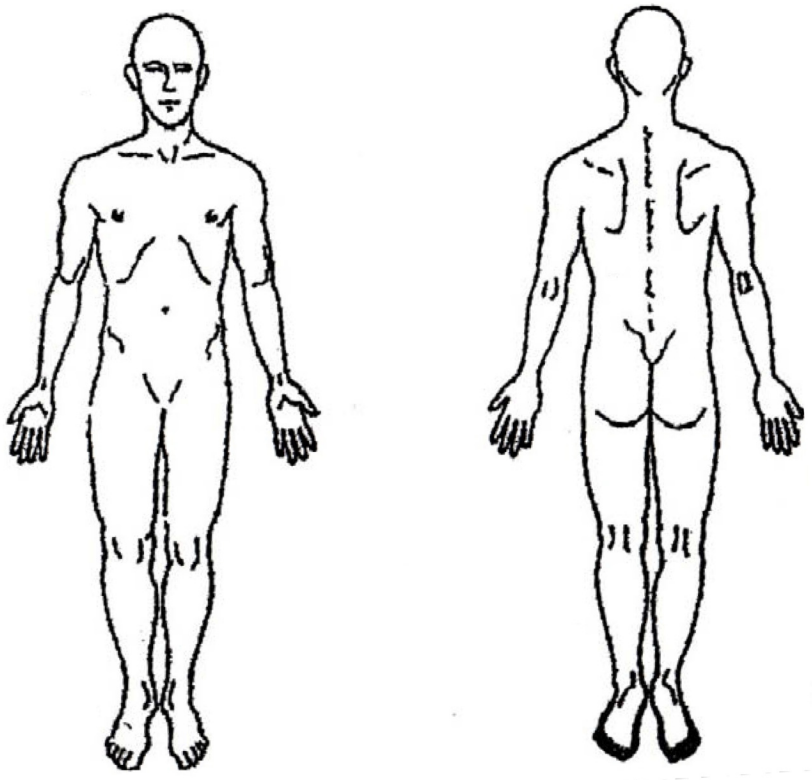
Burning	Stabbing	Throbbing
xxxxx	//////	~~~~~
xxxxx	//////	~~~~~



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. In the past week, how much has pain interfered with your daily activities?

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

5. How often are your symptoms present? _____ %

What are you concerned about today? _____

_____

_____

_____