Patient Name: _____ Today's Date:_____

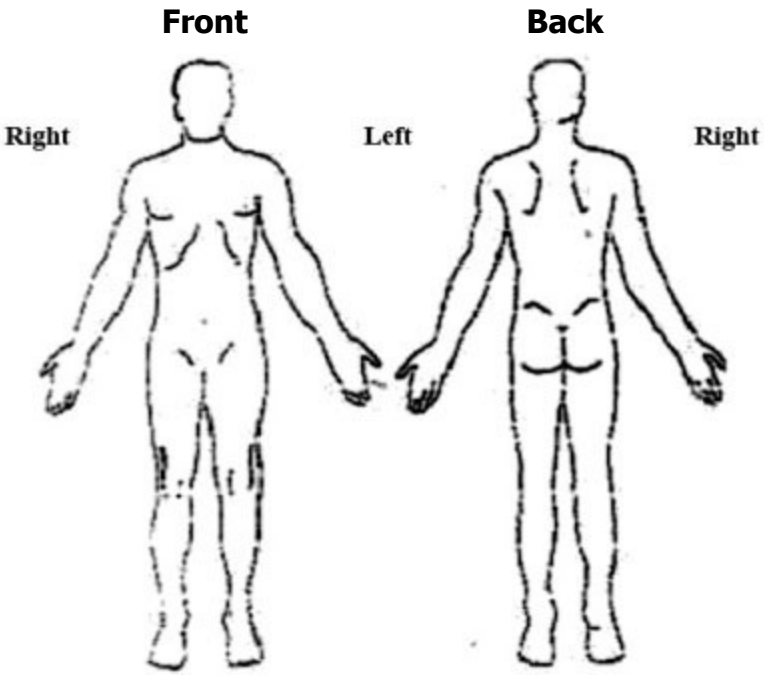
Date of Birth:_____

MRN:_____

PAIN DIAGRAM

Please mark where you are feeling pain.

Numbness xxxxx
Pins/Needles ooooo
Burning - - - - -
Stabbing ///////
Ache/Stiff >>>>



On a scale of 0 to 10, where would you rank your pain now? Please circle the appropriate number:

(no pain) **0 1 2 3 4 5 6 7 8 9 10** (most severe pain)