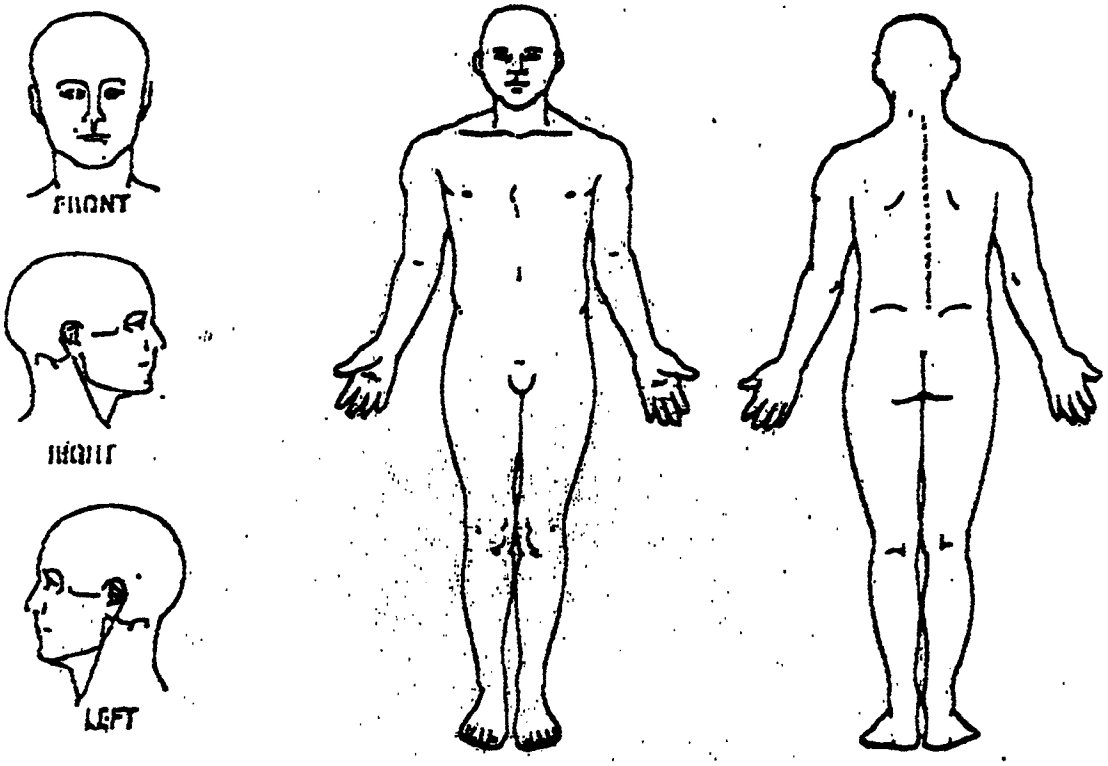
PATIENT PAIN RATING

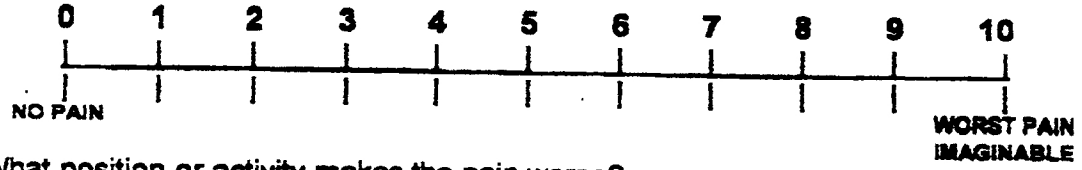
NAME_____ **DATE**_____

1. On the diagram below, please put an "X" in the area(s) of pain and put an "O" in the area(s) of numbness and/or tingling.



2. Average intensity of pain – circle one or more numbers

INTENSITY OF PAIN
PAIN SCALE



3. What position or activity makes the pain worse?_____
4. What position or activity reduces the pain?_____
5. What medications do you take? Approximately how often? For treatment of what condition? Please fill in table below.

Name of Medication	Frequency (per day, per week, etc.)	Condition