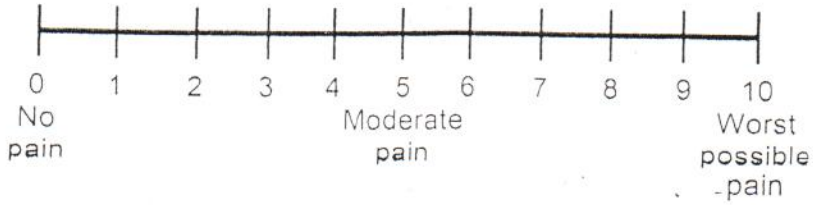
Patient Name:_____ Date:_____

Date of Birth:_____

PRIMARY COMPLAINT

0–10 Numeric Pain Rating Scale

Please indicate on the scale below the level of pain that you are experiencing today.

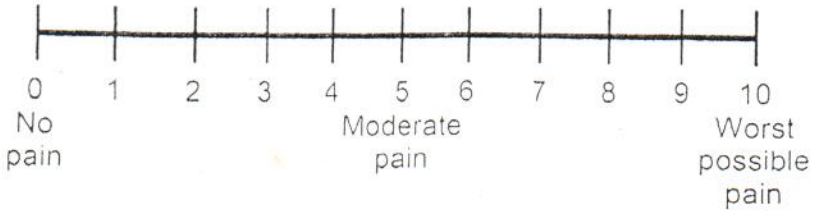


SECONDARY COMPLAINT

(If Applicable)

0–10 Numeric Pain Rating Scale

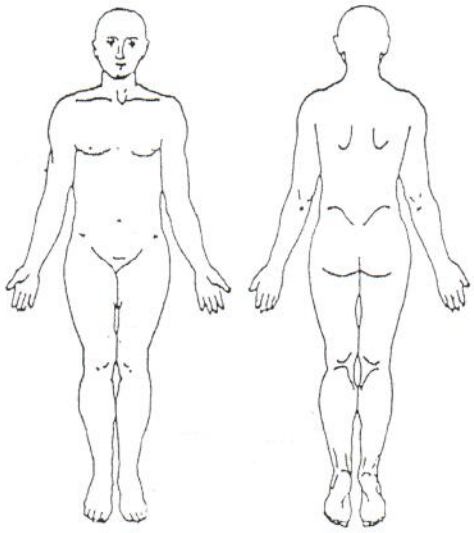
Please indicate on the scale below the level of pain that you are experiencing today.



Where is Your Pain?

Please mark on the drawings below, the areas where you feel pain.

"S"-Sharp/Stabbing "B"-Burning "D"-Dull "T"-Tingling "P"-Pain (General)



Office Use:

Dx:_____

Onset:_____