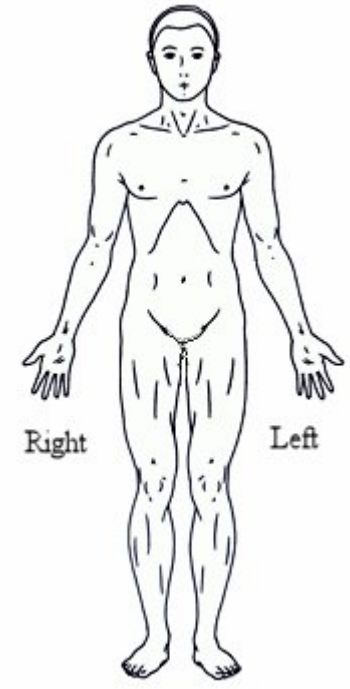
PATIENT NAME: _____

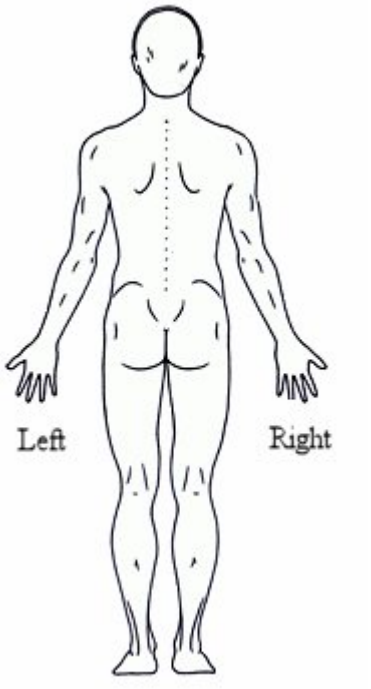
TODAY I FEEL:

About the same _____
Somewhat improved _____
Much improved _____
No more complaints _____
Change in complaint _____
New complaint _____
Other _____

Time of day when pain is worst: __Morning __Afternoon __Evening __Wakes Me
Does the pain radiate? _____
Please circle on the pain scale from 0 to 10 the pain you feel with this condition.
10 being the worst pain you have felt with this condition, 0 being no pain.
Mark areas of pain on figures below.
Type of Pain: __Stiffness __Burning __Numb/Tingling __Sharp __Soreness/Achy

Pain Chart





Neck Pain
0 1 2 3 4 5 6 7 8 9 10

Shoulder, Arm Pain
0 1 2 3 4 5 6 7 8 9 10

Mid Back Pain
0 1 2 3 4 5 6 7 8 9 10

Low Back Pain
0 1 2 3 4 5 6 7 8 9 10

Hip, Leg Pain
0 1 2 3 4 5 6 7 8 9 10

Foot, Ankle Pain
0 1 2 3 4 5 6 7 8 9 10

Other Pain
_____

Date: _____ Signature _____