Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

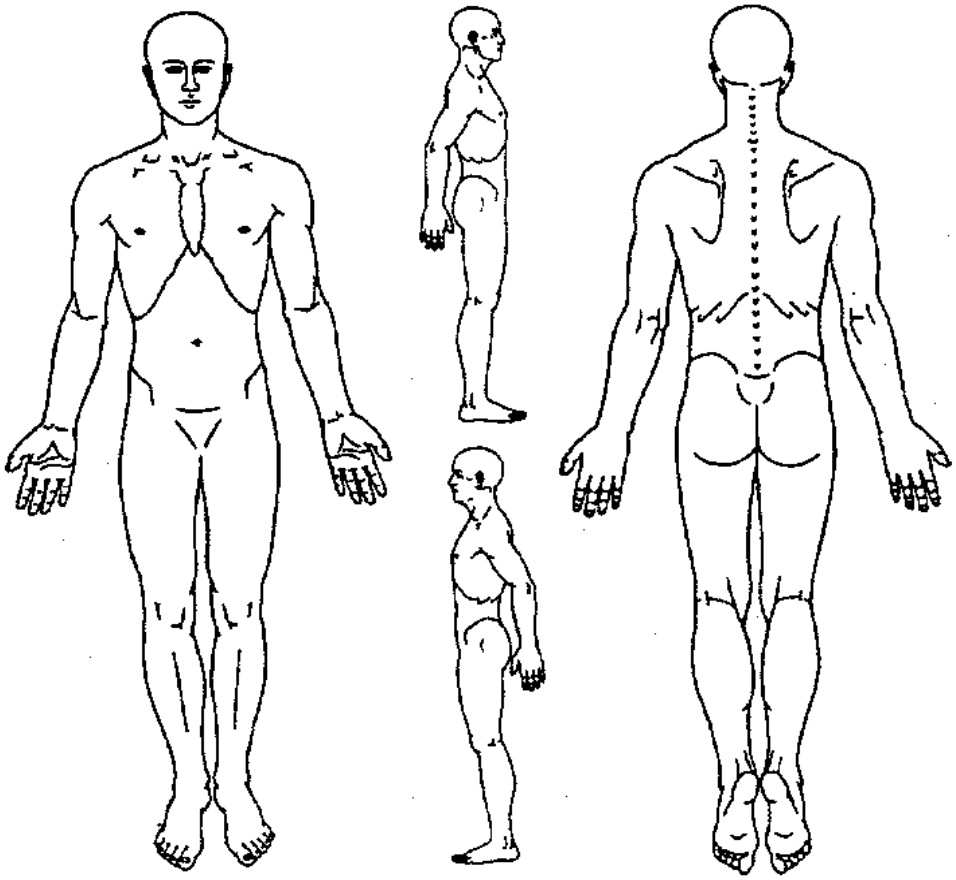
Numbness: ----- Burning: ^^^^ Pins & Needles: oooo Stabbing: Ø Ø Ø Aching: xxxx

Using the pain scale 1-10, please put a number that describes each

Best _____ Worst _____ Current _____

Percentage Of Improvement Since **Last Visit:** At Best _____

Currently_____



Right Left Left Left Right

Please use the space below to describe your condition further if needed:

_____

_____

_____

How much time does your pain cause you to miss work or prevent household chores?

_____<25% _____25-50% _____50-75% _____75-100%

Date: _____ Signature: _____

Please complete both sides:

Do you have any of the following problems?

General: ___fevers ___chills ___sweats ___loss of appetite ___fatigue ___weight loss

Eyes: ___blurring ___vision loss ___trouble with bright light

Ears/Nose/Throat: ___ringing ___decreased hearing ___nasal congestion
___sore throat ___hoarseness ___trouble swallowing

Cardiovascular: ___chest pains ___palpitations ___shortness of breath on exertion ___swelling in legs

Respiratory: ___cough ___shortness of breath ___wheezing __current smoker

Gastrointestinal: ___nausea ___vomiting ___diarrhea ___constipation
___ abdominal pain

Genitourinary: ___trouble with urination ___need to urinate at night ___incontinence ____Increased frequency

Musculoskeletal: ___back pain ___neck pain ___joint pain ___joint swelling ___muscle cramps
___muscle weakness ___stiffness ___arthritis

Skin: ___rash ___itching ___dryness ___suspicious lesions

Neurologic: ___temporary paralysis ___weakness ___seizures
___syncope or passing out

Psychiatric: ___depression ___anxiety ___memory loss

Endocrine: ___cold intolerance ___heat intolerance ___frequent urination
___weight change

Heme/lymphatic: ___abnormal bruising ___bleeding ___enlarged lymph nodes

Allergic/Immunologic: ___hay fever ___persistent infections ___HIV exposure

Do you drink alcohol? _____ How often? _____ # of drinks per week _____

Did you get a flu vaccine this year? _____Have you ever received the pneumonia vaccine?_____

Please rate the following activities of daily living since having begun your current treatment plan for your pain using an X to mark the appropriate box.

	Better	Same	Worse
Daily activities			
Work duties			
Mood			
Family relationships			
Social relationships			
Sleep pattern			
Overall functioning			