Patient Pain Form

Name:	Claim No:
DOI:	Date:
Please circle on the lin	ne below the level or intensity of pain you are presently experiencing:
Absolutely Pain Free_	Worse Pain You Could Ever Have 1 2 3 4 5 6 7 8 9 10
Using the symbols list where you feel the des	sted below, mark on the two drawings below which areas on your body scribed sensations:
Numbness	===
Dull Ache	
Hot Burning	x x x
Sharp Stabbing	$///$ $/\lambda$ λ
Pins and Needles	+++ //) (\\
Other	Right Left Left Right
Signature	Date

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