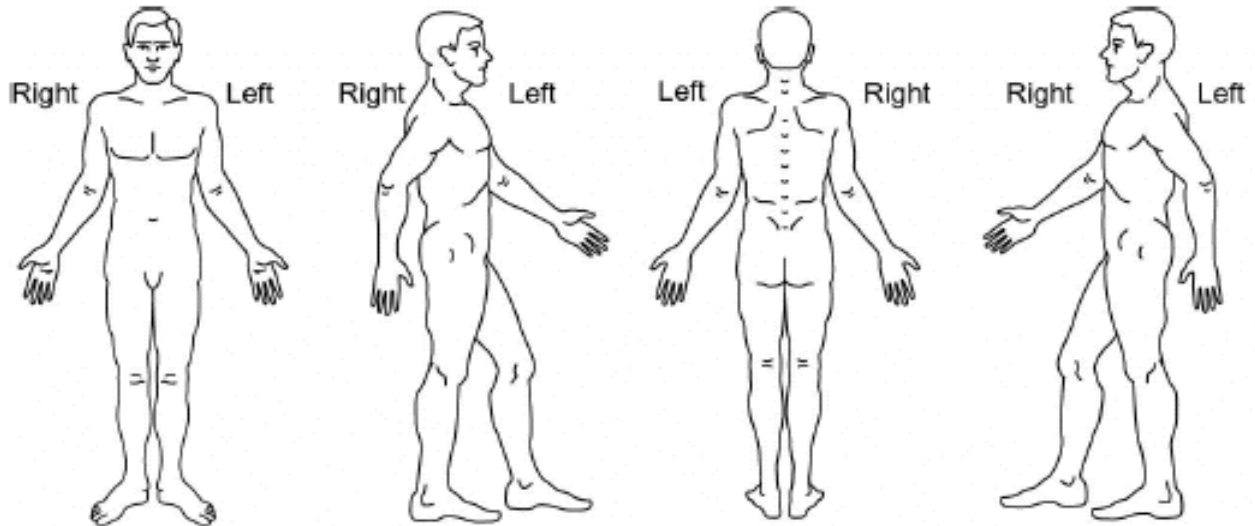


Patient Pain Assessment

Please indicate where your pain is located using the picture below



Please use the scale below to answer the following questions

NO PAIN AT ALL 0 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN

Please rate your current pain level: _____ Your pain at its worst: _____ Your pain at its best: _____

Please describe your pain (e.g. sharp, shooting, stabbing): _____

Please describe the frequency of your pain (e.g. constant, intermittent): _____

Please tell us what relieves your pain (e.g. rest, medication): _____

Please tell us what makes your pain worse (e.g. lifting, sitting, bending): _____

Patient Signature

Therapist Signature

Date