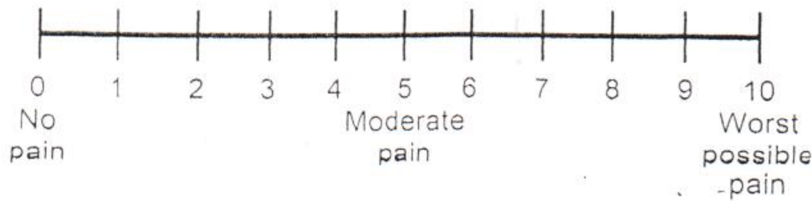
Patient Name:____________________ Date:________________

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.

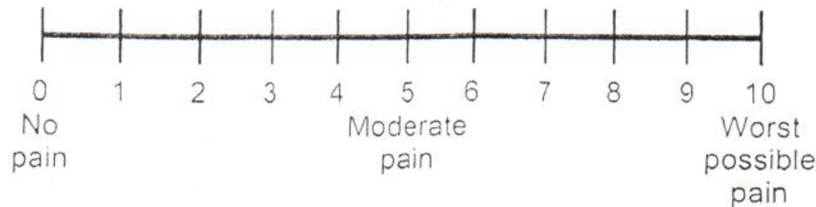


SECONDARY COMPLAINT

(If Applicable)

0–10 Numeric Pain Rating Scale

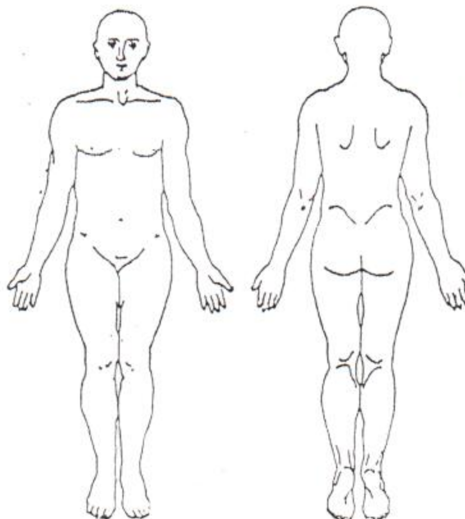
Please indicate on the scale below the level of pain that you are experiencing today.



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:____________