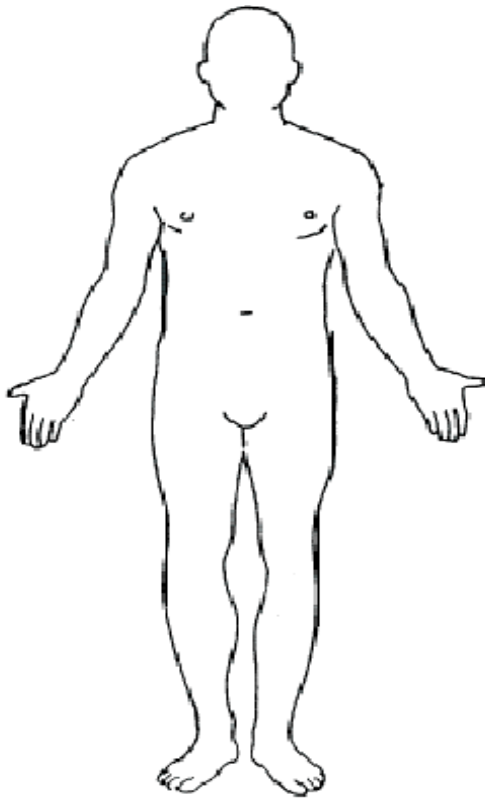


Name: \_\_\_\_\_ Clinic ID: \_\_\_\_\_ Date: \_\_\_\_\_

**INSTRUCTIONS: Please circle the number that best describes your pain**

No Pain \_\_\_\_\_ Worst Pain \_\_\_\_\_

1      2      3      4      5      6      7      8      9      10



On the figures to the right and left, please mark the area or areas you are having pain with the appropriate symbols.

Numbness

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Pins and Needles

0000

Burning

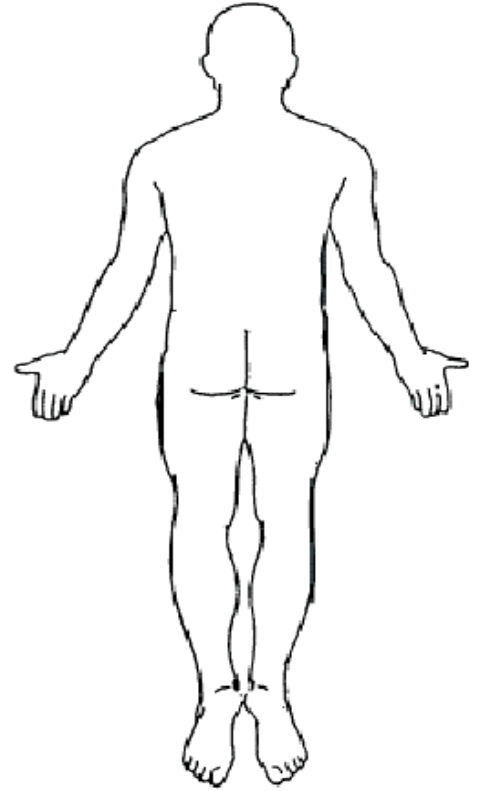
xxxxx

Ache

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Sharp

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Patient Initials: \_\_\_\_\_ Doctor's Initials: \_\_\_\_\_

Comments:

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