



Write the number representing the pain intensity (0-10) below and mark the area of pain on the drawing.

(0= No pain, 10= Worst imaginable pain)

Head____, Neck____, Upper back____, Mid-back____,
Low back____, Chest____, Abdomen____,
R/L buttocks____, R/L upper/lower extremity____
Other: _____

Pain Quality (Please Circle)

1. Throbbing, Shooting, Stabbing, Sharp, Cramping, Burning, Aching, Stiffness, Heavy, Tender, Splitting, Numbness, Tingling
2. Tiring, Exhausting, Sickening, Fearful, Punishing-Cruel

Mood: Good____ Depressed____ Irritated____
Appetite: Good____ Bad____
Sleep: Good____ Bad____ Pain wakes me ____ times/night

Pain Intensity (CIRCLE ONE ONLY)
1-Mild
2-Discomforting
3-Distressing
4-Horrible
5-Excruciating

Instructions: Circle one number one each line:	Limited A Lot		Limited A Little		Not Limited	
	5	4	3	2	1	0
Dress and bathe self	5	4	3	2	1	0
Bend, kneel or stoop	5	4	3	2	1	0
Lift and carry groceries	5	4	3	2	1	0
Walk one block	5	4	3	2	1	0
Walk several blocks	5	4	3	2	1	0
Walk more than a mile	5	4	3	2	1	0
Climb a flight of stairs	5	4	3	2	1	0
Climb several flights of stairs	5	4	3	2	1	0
Moderate activities such as vacuuming, golf, bowling, moving a table	5	4	3	2	1	0
Vigorous activities such as running or lifting heavy objects	5	4	3	2	1	0
Perform one's job	5	4	3	2	1	0

Patient Notes _____

Relief Scale (after last treatment)

No Relief | 50% Relief | Complete Relief

Relief Scale (overall improvement)

No Relief Of Pain | 50% Relief | Complete Relief Of Pain

How long did your relief last? _____
Overall Function: Better____ Worse____ Same____
Pain Intensity: Decreased____ Increased____ Same____
Pain Duration: Shorter____ Longer____ Same____
Pain Localization: No changes____ Changed____
Pain Character: Same____ Different____
 Describe changes: _____

Office Notes _____

Name _____
Date _____

BP _____ / _____
PR _____ PO2 _____