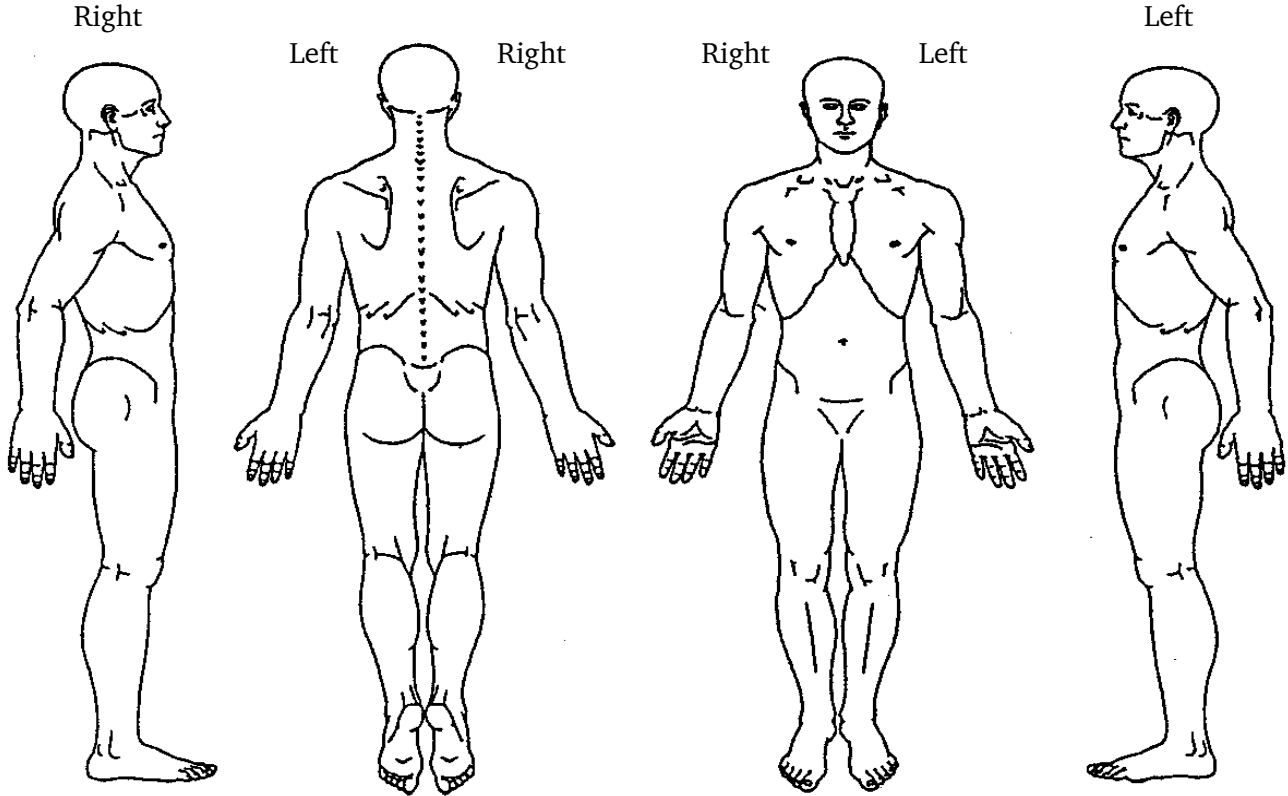


PATIENT PAIN CHART

Name _____ Date _____ Time _____ am pm

- 1 Please **draw** your areas of involvement on the figures below and label the **type** or **nature** of the sensation of each area (i.e. pain, ache, numbness, electrical, pressure, tight, sore, weak, tired, etc.) **and** whether it is dull, sharp, burning, tingling (pins & needles), shooting, throbbing, stabbing, etc.
- 2 Then rate each for **intensity** on a scale of 1-10 with 1 being the least and 10 being the worst possible.



Severity & Duration of episodes _____

Constant (76-100% of time awake) _____

Frequent (51-75%) _____

Intermittent (26-50%) _____

Occasional (1-25%) _____

Additional Information _____
