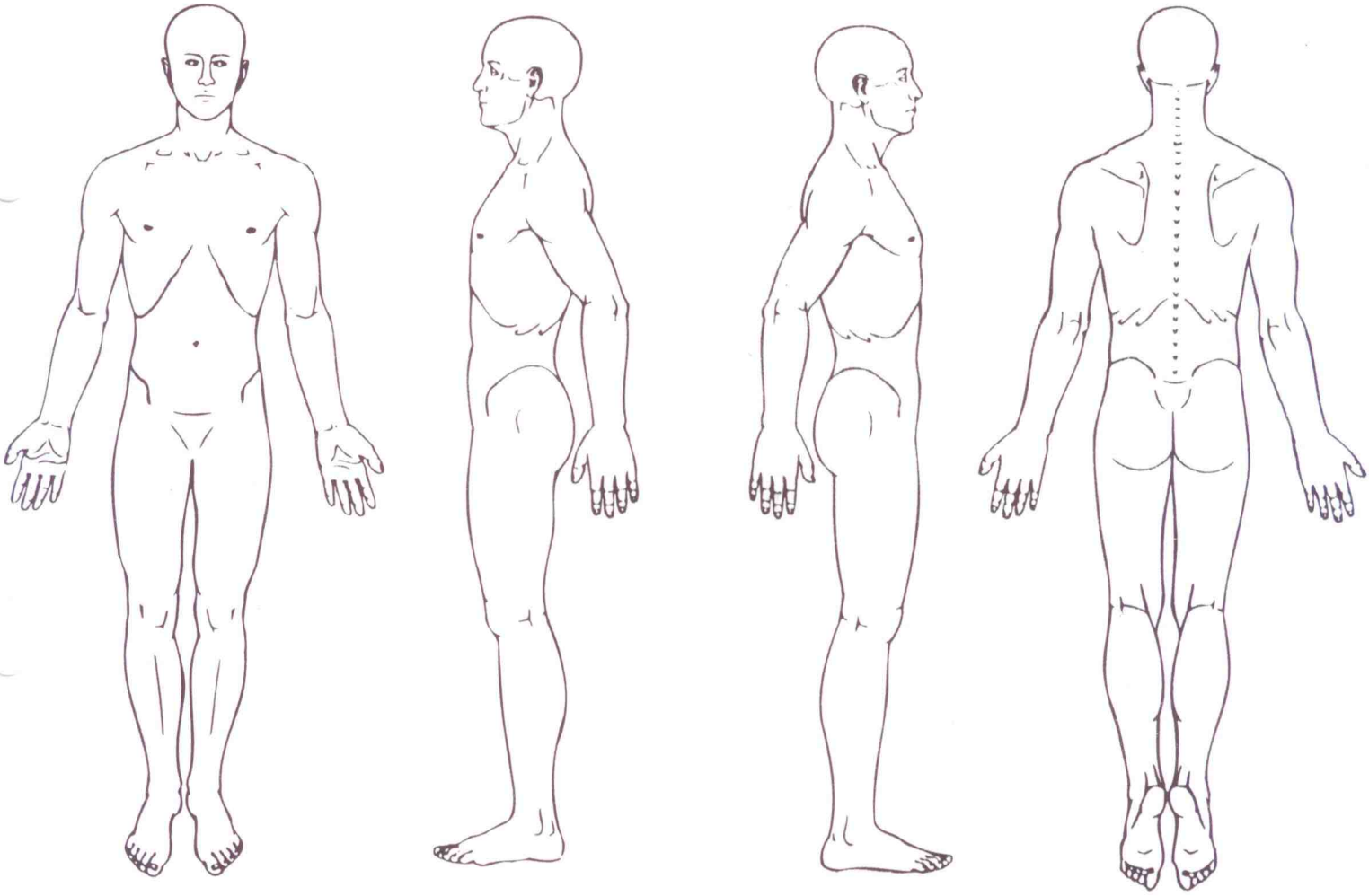
PAIN ASSESSMENT

Name: _____ Date: _____

1. ☐ Initial Visit ☐ Follow-up Visit

2. Please mark or shade the areas of your body where you feel pain on the diagrams below.



3. Next to each area marked above, please note the intensity of pain.

No Pain		Minimal		Tolerable, but hinders activities		High - 50% of activities impaired		Extreme - most activities impaired		Unbearable
0	1		2	3	4	5	6	7	8	9