PEACHTREE ORTHOPAEDIC CLINIC

Name:_____ Date:_____

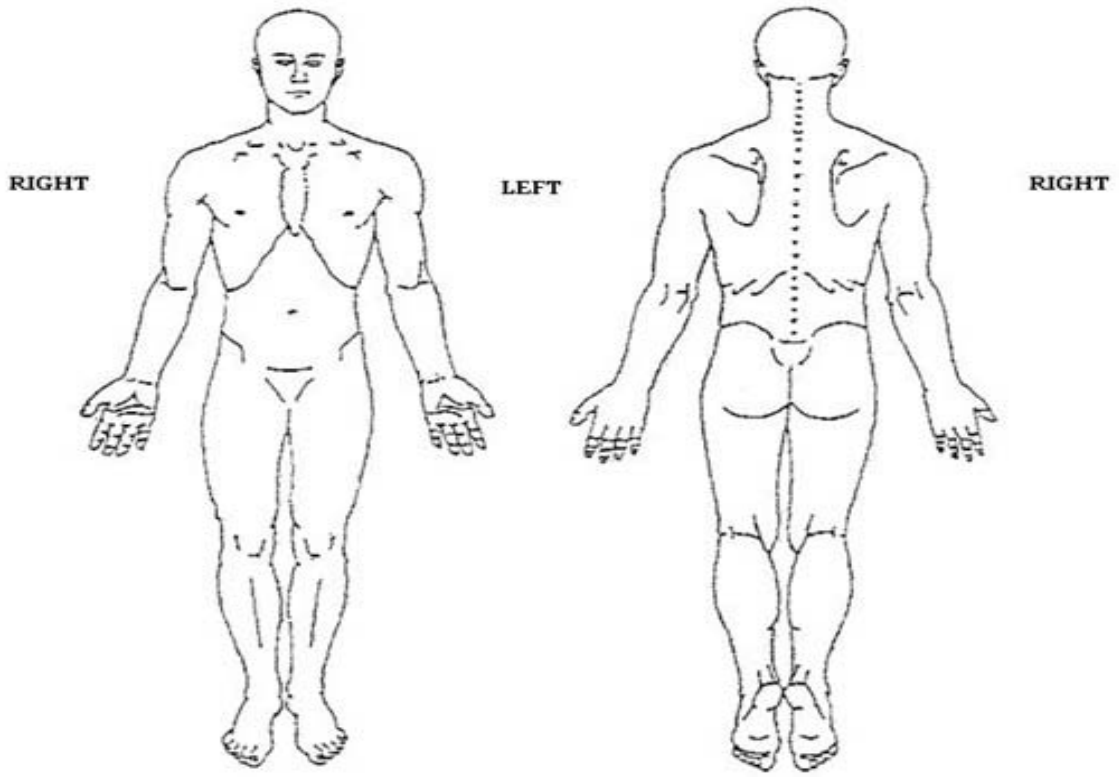
Age: _____ Initial Visit: _____ Follow up: _____ Preprocedure: _____ Postprocedure: _____

PAIN DIAGRAM

Please mark these drawings according to where you hurt. Please indicate which sensations you feel by referring to the key (symbols) below.

Key:

Stabbing **///** Burning **XXX** Pins & Needles **000** Numbness **===** Aching **++**



Left Right Right Left

Pain Level: 0 1 2 3 4 5 6 7 8 9 10

(Please check the worst & best your pain has been and circle your current pain level according to the key on the right.)

KEY:

0	No pain
1	Mild pain – you are aware of it, but it doesn't bother you
2	Moderate pain that you can tolerated without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain – you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain – it may make you contemplate suicide