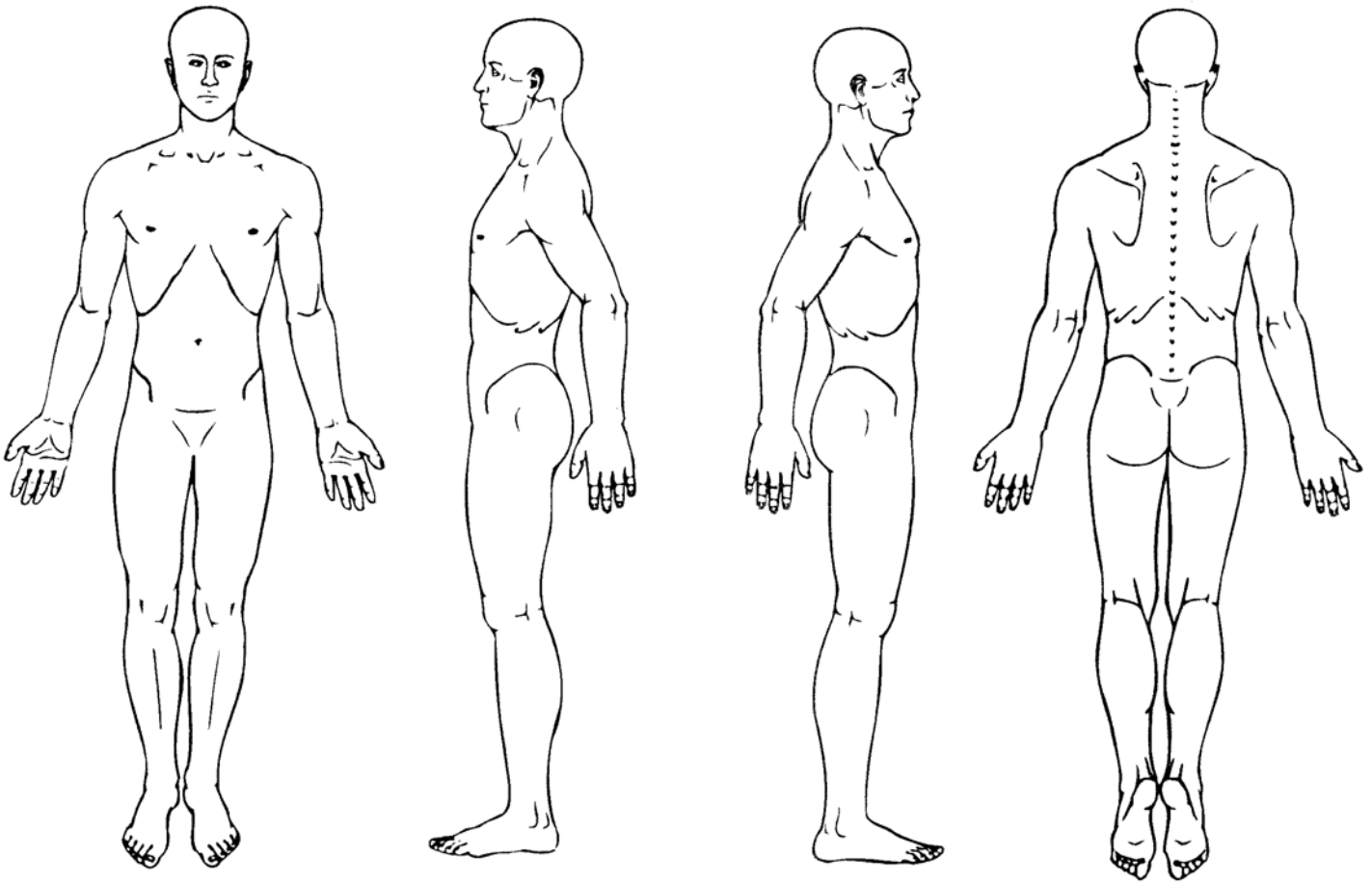


PAIN ASSESSMENT

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