

Please tell us about your pain.

List the problem area(s) separately and answer the following questions regarding your affected area(s).

Problem 1: _____ Started when? _____

How often is problem present? Constant frequent occasional seldom

Quality of Pain? dull aching sharp shooting burning throbbing deep nagging other _____

Have you had your main problem before? Yes No If yes, when? _____

Rate the pain from 1 to 10 (1 is little or no pain, 10 is severe pain) 1 2 3 4 5 6 7 8 9 10

Other Information: _____

Problem 2: _____ Started when? _____

How often is problem present? Constant frequent occasional seldom

Quality of Pain? dull aching sharp shooting burning throbbing deep nagging other _____

Have you had your main problem before? Yes No If yes, when? _____

Rate the pain from 1 to 10 (1 is little or no pain, 10 is severe pain) 1 2 3 4 5 6 7 8 9 10

Other Information: _____

Problem 3: _____ Started when? _____

How often is problem present? Constant frequent occasional seldom

Quality of Pain? dull aching sharp shooting burning throbbing deep nagging other _____

Have you had your main problem before? Yes No If yes, when? _____

Rate the pain from 1 to 10 (1 is little or no pain, 10 is severe pain) 1 2 3 4 5 6 7 8 9 10

Other Information: _____

Mark the areas of pain on the figures below. Include all affected areas. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels.

