Patient Pain Form

Name:

Date:

Claim No:

DOI:

Physician Office Use Only

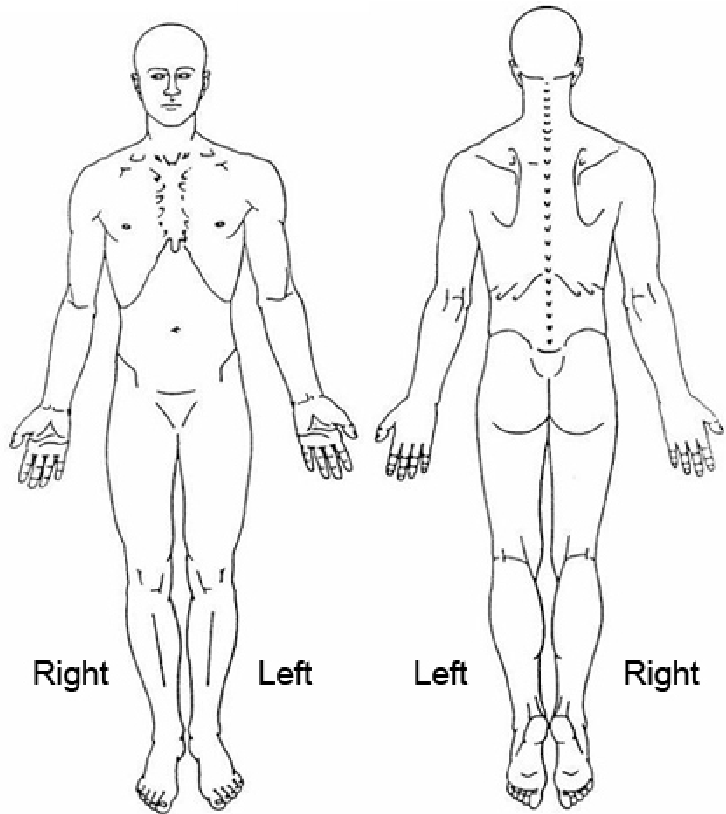
File # ___________________

Please Circle on the line below the level or intensity of pain you are presently experiencing:

Absolutely Pain Free 1 2 3 4 5 6 7 8 9 10 Worst Pain You Could Ever Have

Using the symbols listed below, mark on the two drawings below which areas on your body where you feel the described sensations:

Numbness	- - -
Dull Ache	o o o
Hot Burning	X X X
Sharp Stabbing	/ / /
Pins and Needles	+ + +
Other __________ __________	. . .



Signature: ____ Date: ________________

Physician Comments: