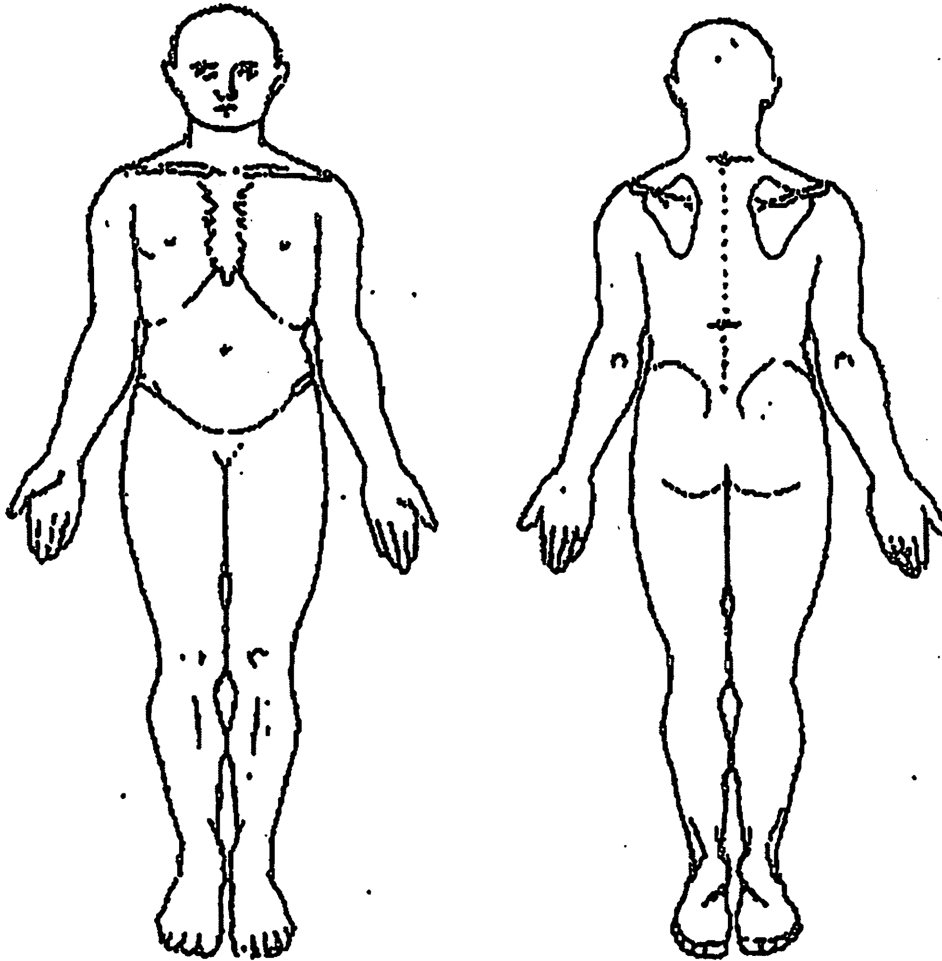
Name:_ Signature:_______________________________

Date:_______________________

Please use the drawings below to indicate where you feel symptoms right now. Shade in all areas where you feel pain.



Please use the three scales below to rate the intensity of your pain over the past 24 hours. Use the upper number scale to describe your pain right now. Use the middle scale to describe the worst pain you have experienced since this time yesterday. Use the lower scale to describe the least amount of pain you have felt since this time yesterday.

RATE YOUR PAIN	0=no pain								10=severe pain		
Right Now	0	1	2	3	4	5	6	7	8	9	10
Worst in 24 hours	0	1	2	3	4	5	6	7	8	9	10
Least in 24 hours	0	1	2	3	4	5	6	7	8	9	10