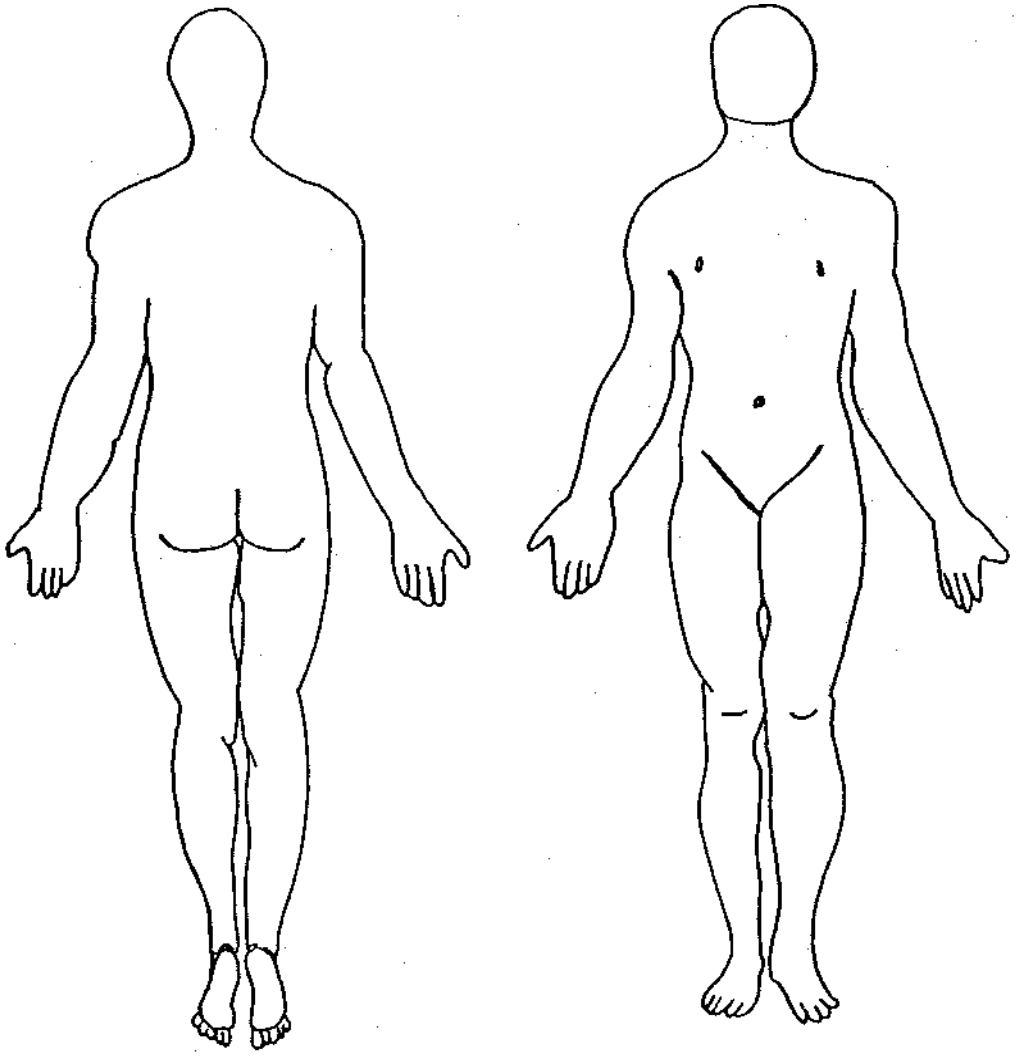
NAME: _____ **DATE:** _____

PLEASE FILL OUT THIS PAIN DIAGRAM TO THE BEST OF YOUR ABILITY. MARK THE AREAS ON YOUR BODY WHERE YOU HAVE PAIN, AREAS OF NUMBNESS OR TINGLING, OR ANY OTHER BOTHERSOME SENSATION. PLEASE INCLUDE ALL AFFECTED AREAS AS WELL AS THE RADIATION OF SYMPTOMS. USE THE APPROPRIATE SYMBOLS BELOW. **PLEASE FILL OUT THE PAIN SCALE.**

NUMBNESS:00000 **PINS & NEEDLES:**XXXXX **PAIN OR ACHE:**/////



RATE YOUR PAIN	0=NO PAIN									10=EXTREMELY INTENSE
RIGHT NOW:	1	2	3	4	5	6	7	8	9	10
AT ITS WORST:	1	2	3	4	5	6	7	8	9	10
AT ITS BEST:	1	2	3	4	5	6	7	8	9	10