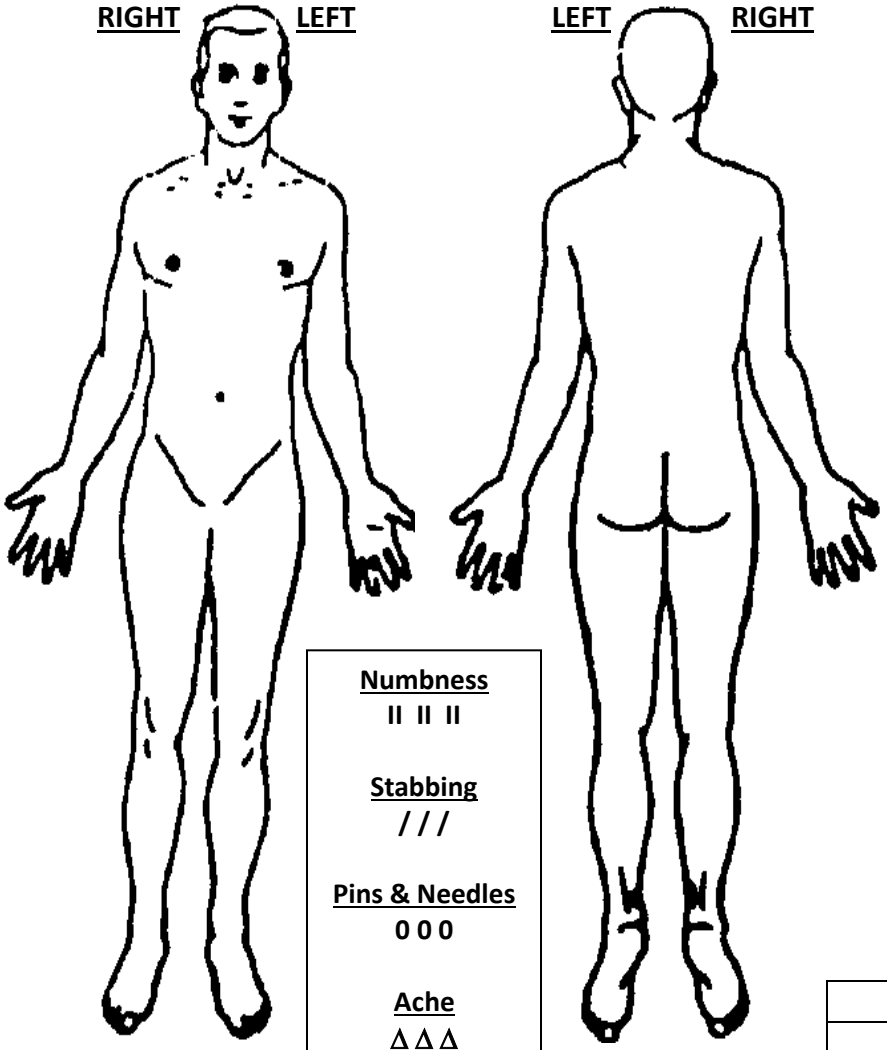
Port City Neurosurgery & Spine

Today's Date: _____

Patient Pain Indicators

Patient Name: _____ DOB: _____

Using the **symbols** shown below, mark the areas on the figure drawings that show where you feel the described sensations. Please include all areas **affected by pain**.



Numbness
II II II

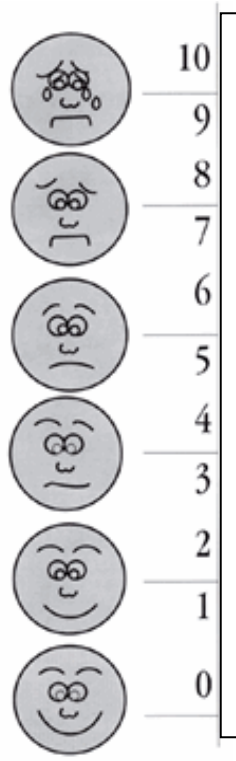
Stabbing
/ / /

Pins & Needles
0 0 0

Ache
Δ Δ Δ

Burning
X X X

Circle the number that represents your current pain level.



10	Worst Pain Possible, Unbearable
9	
8	Intense, Dreadful, Horrible
7	
6	Miserable, Distressing
5	
4	Nagging Pain, Uncomfortable, Troublesome
3	
2	Mild Pain, Annoying
1	
0	No Pain

How does each of the following affect your pain?

	Better	Worse	No Change
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Lying down	☐	☐	☐
Raising from chair	☐	☐	☐
Physical activity	☐	☐	☐

(Please check): What type of pain do you feel? ☐ Sharp ☐ Dull ☐ Burning ☐ Radiating

Pain is: ☐ Constant ☐ On & Off

Is one area of pain worse than another? If yes, please indicate where: _____