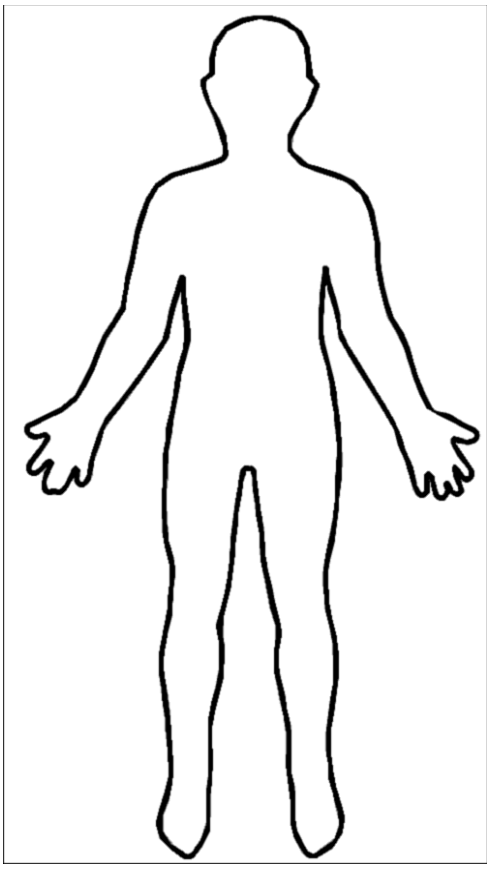
PATIENT PAIN DRAWING

Name_____ **Date** _____

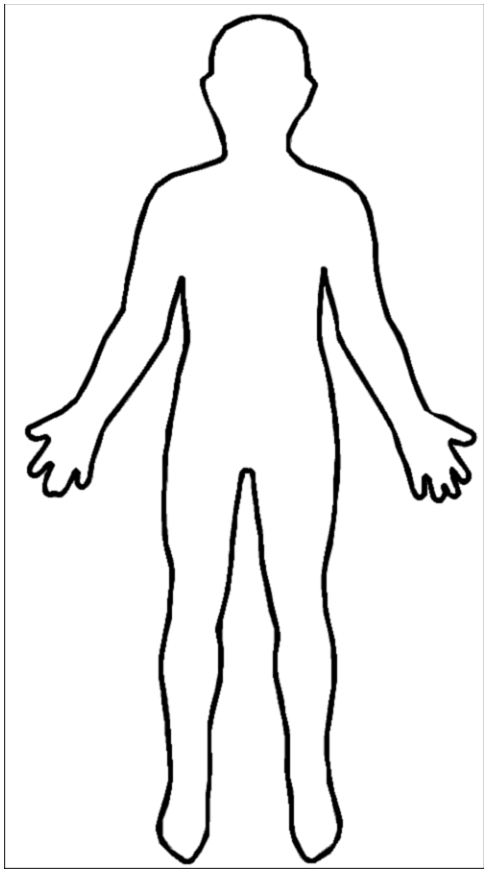
Where is your pain now?

- **Mark the areas on your body where you feel the sensations described below, using the appropriate system**
- **Mark the areas of radiation**
- **Include all affected areas**
- **To complete the picture, please draw in your face**

Aching	Numbness	Pins and Needles	Burning	Stabbing
^ ^ ^	= = =	o o o	x x x	/ / /



Front



Back

How bad is your pain now?

Please mark with an X on the body form where the pain is worst now.
Please mark on the line how bad your pain Is now:

No Pain ____|____|____|____|____|____|____|____|____|____|____ **Worst Pain**

1 2 3 4 5 6 7 8 9 10