Family Tree
chiropractic and wellness

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PATIENT PAIN FORM

Patient Name: _____ Date: ____/_____/___ Chart # _____

Date of Injury _____/_____/_____ Claim/Soc.Sec.# _____

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

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

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

Numbness = = =

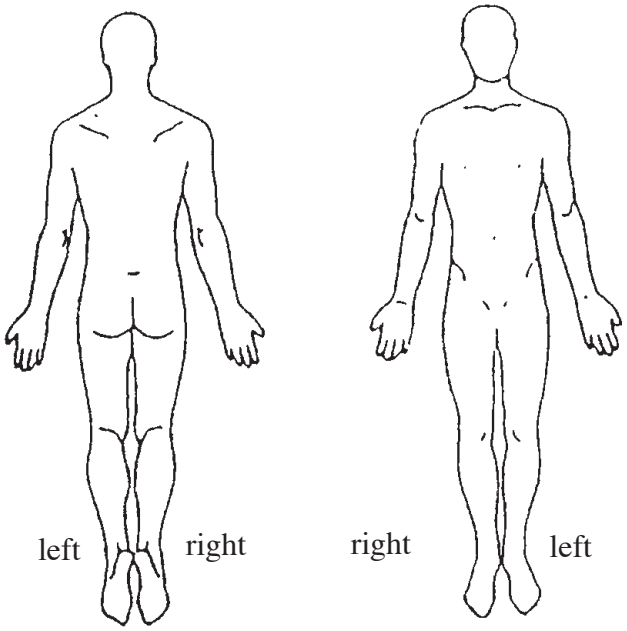
Dull Ache 0 0 0

Hot Burning X X X

Sharp Stabbing / / /

Pins and Needles + + +

Other _____ • • •



Signature : _____ Date:_____

Physician Comments : _____
_____
_____
_____