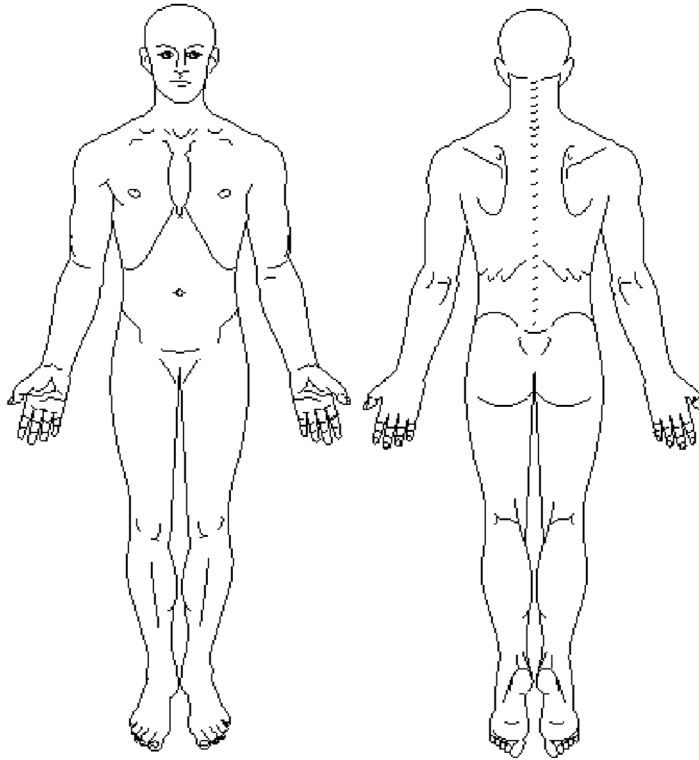


## PAIN/SYMPTOM DIAGRAM

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please indicate where you have pain or other symptoms by marking on the diagram below:



For the following questions use the pain scale listed below:

0      1      2      3      4      5      6      7      8      9      10  
No Pain      Mild Pain      Moderate Pain      Severe Pain Unbearable

What is your pain level at rest? \_\_\_\_\_

What is your pain level at best? \_\_\_\_\_

What is your pain level with activity? \_\_\_\_\_

What is your pain level at worst? \_\_\_\_\_