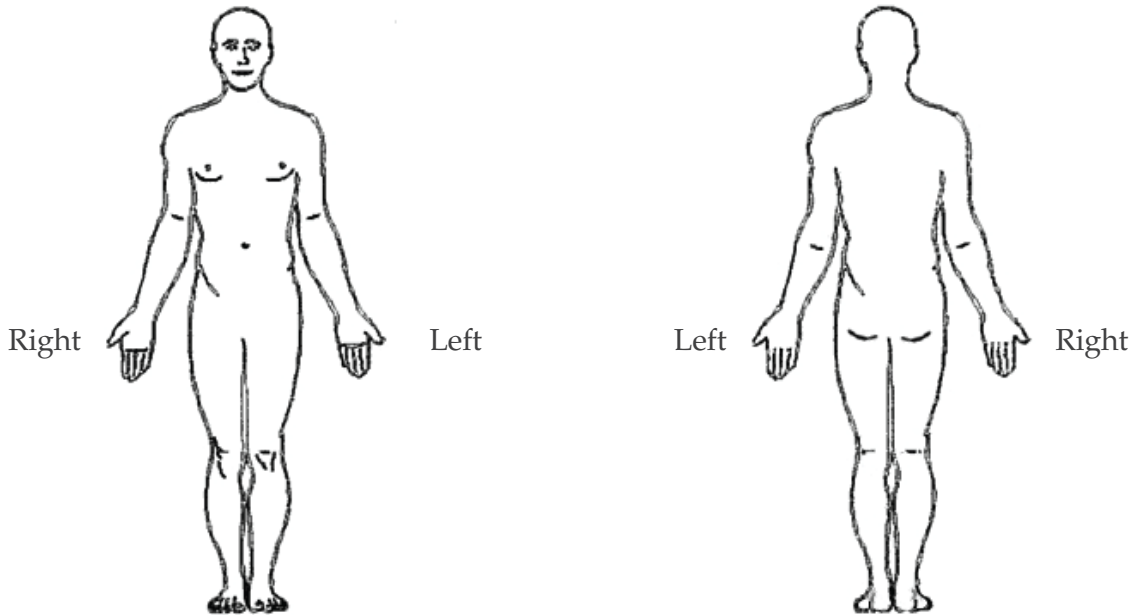


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Name: \_\_\_\_\_ Date: \_\_\_\_\_

WHERE IS YOUR PAIN? Please mark all painful areas on the diagram below.



INTENSITY: How bad is the pain? (Circle the appropriate number: 0 = no pain - 10 = worst pain)

0 1 2 3 4 5 6 7 8 9 10

PAIN CHARACTERISTICS: (check all that apply) Sharp\_\_\_ Dull\_\_\_ Burning\_\_\_ Aching\_\_\_

Pressure\_\_\_ Pins and Needles\_\_\_ Other \_\_\_\_\_

WHEN DID THIS START? (Approximately) \_\_\_\_\_

WHAT DO YOU THINK HAPPENED TO CAUSE IT? \_\_\_\_\_

WHAT MAKES IT WORSE? \_\_\_\_\_

TIMING: Constant?\_\_\_ Worse during: morning?\_\_\_ afternoon?\_\_\_ evening?\_\_\_ night?\_\_\_