

# Patient Pain Form

Name:

Date:

Claim No:

DOI:

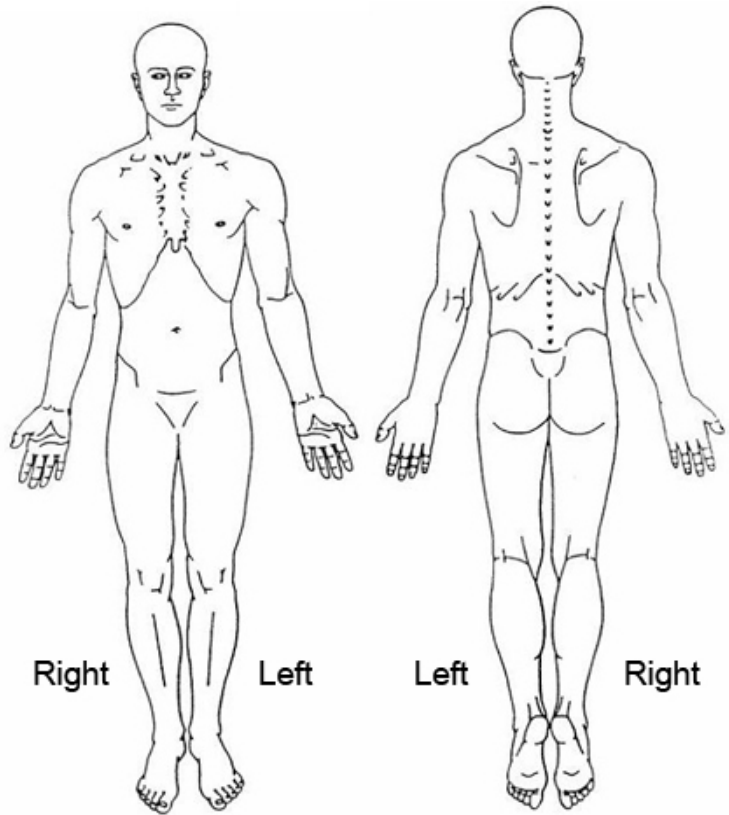
Physician Office Use Only  
File # \_\_\_\_\_

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

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

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

- Numbness                    - - -
- Dull Ache                    o o o
- Hot Burning                X X X
- Sharp Stabbing            / / /
- Pins and Needles         + + +
- Other \_\_\_\_\_         . . .
- \_\_\_\_\_



Signature: \_\_\_\_\_

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

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**Physician Comments:**