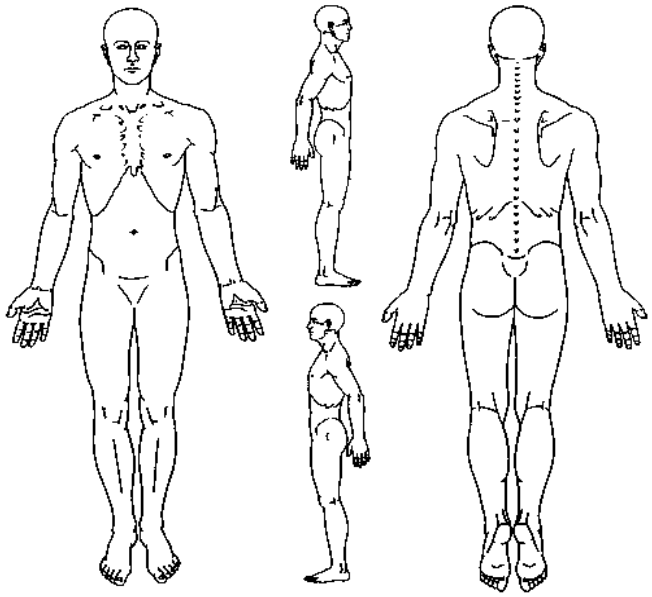
Premier
PAIN MANAGEMENT, LLC

NAME_____ DATE_____

HOW LONG HAVE YOU HAD PAIN ____years ____months ____weeks

On the Diagram below, please indicate where you are experiencing pain or other symptoms, right now.

A = ACHE	**B** = BURNING	**N** = NUMBNESS
P = PINS & NEEDLES	**S =** STABBING	**O =** OTHER



1 – What is your pain RIGHT NOW?

No Pain _____ **Worst Pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No Pain _____ **Worst Pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain _____ **Worst Pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain _____ **Worst Pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS: _____