CRANMORE HEALTH PARTNERS
Primary, Pain, and Urgent Care

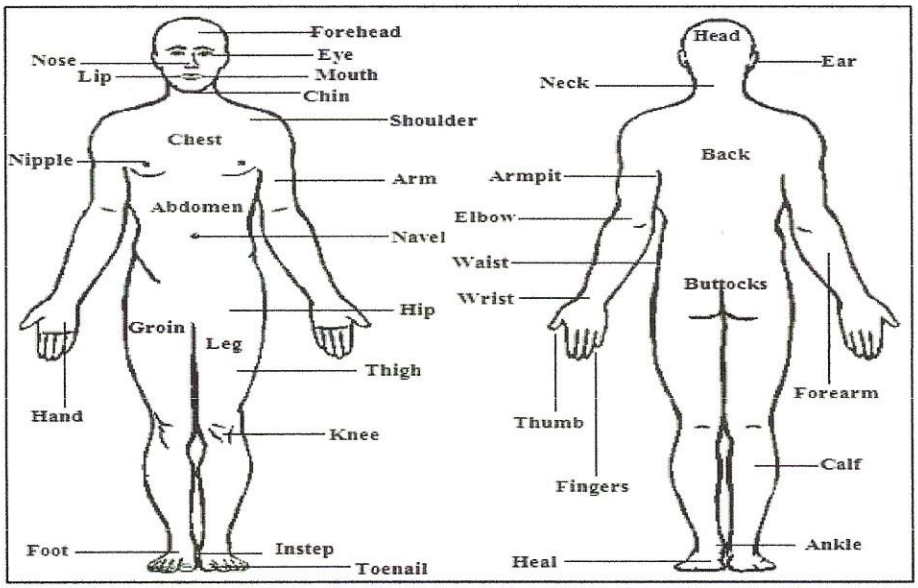
Pain Management Clinic
Pain Diagram and Rating

Patient's Name: _____ Date of Birth: _____

Reason for today's visit: _____

PAIN	Location 1	Location 2	Location 3
Where is your pain?			
When did it start?			
How did it begin? (Suddenly, Gradually, Injury, At Work, Fall, etc.)			
What does it feel like? (Burning, Aching, Sharp, Dull, Shooting, etc.)			

Please draw on the diagram where your pain is located



(Circle one)

Pain Level Now? (0= no pain, 10=worst imaginable pain)	0	1	2	3	4	5	6	7	8	9	10
Average pain level over the last month	0	1	2	3	4	5	6	7	8	9	10
Lowest it has been in the last month or two	0	1	2	3	4	5	6	7	8	9	10
Highest it has been in the last month or two	0	1	2	3	4	5	6	7	8	9	10

(Please circle all that apply)

What aggravates your pain? heat cold activity driving lying down sitting standing walking bending lifting weather prolonged positions stress

What relieves your pain? heat cold activity driving lying down sitting standing massage stretching medication changing positions

Associated signs & symptoms: problems sleeping depression anxiety sexual issues decreased range of motion difficulty urinating saddle anesthesia bowel or bladder dysfunction numbness and tingling

Pain is worse in: morning afternoon evening night

Pain is: continuous intermittent