

## Patient Pain Drawing

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.

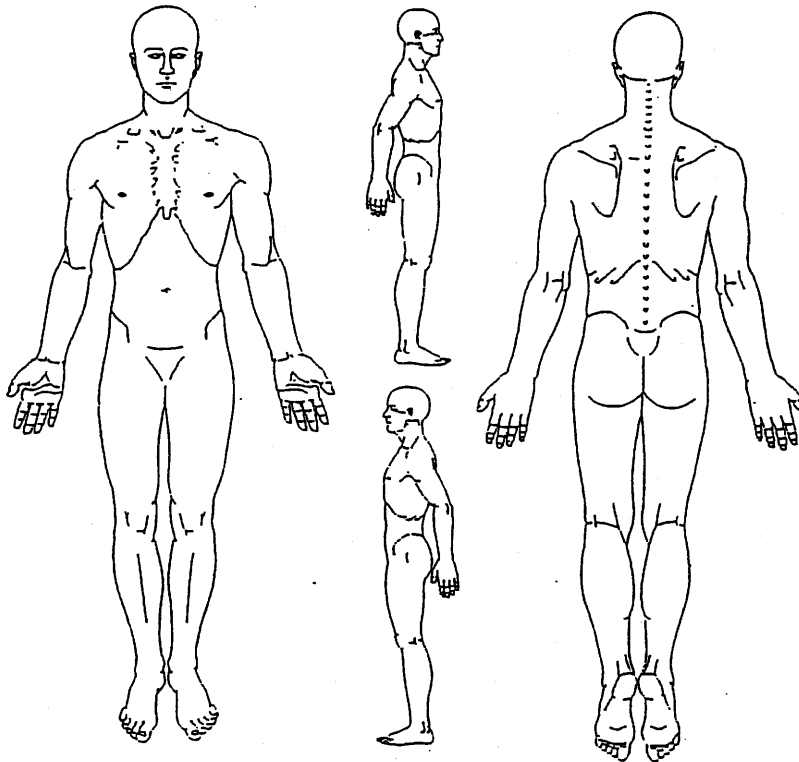
Name (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

How long have you had this symptom? \_\_\_\_\_ Years \_\_\_\_\_ Months \_\_\_\_\_ Weeks  
Is this your first episode of this symptom? \_\_\_\_\_ Yes \_\_\_\_\_ No

**USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW.**

**KEY:** A = ache                      B = burning                      N = numbness  
          P = pins and needles        S = stabbing                      O = other



0    1    2    3    4    5    6    7    8    9    10

No pain

Highest pain

Please rate your current pain by circling the appropriate number above.