

PATIENT PAIN DRAWING

SELF-ASSESSMENT

Name: _____ Date: _____

Please rate your pain level by placing an "X" on the scale below. Should you have additional concerns, please add them to the "Other" sections.

Headache	_____	Absent	Severe
Neck Pain	_____	Absent	Severe
Mid-Back Pain	_____	Absent	Severe
Low Back Pain	_____	Absent	Severe
Other Area: _____	_____	Absent	Severe
Other Area: _____	_____	Absent	Severe

Please indicate your pain on the anatomical figures using the following:

- A = Ache
- B = Burning
- N = Numbness
- P = Pins & Needles
- S = Stabbing
- O = Other

