

# PAIN ASSESSMENT

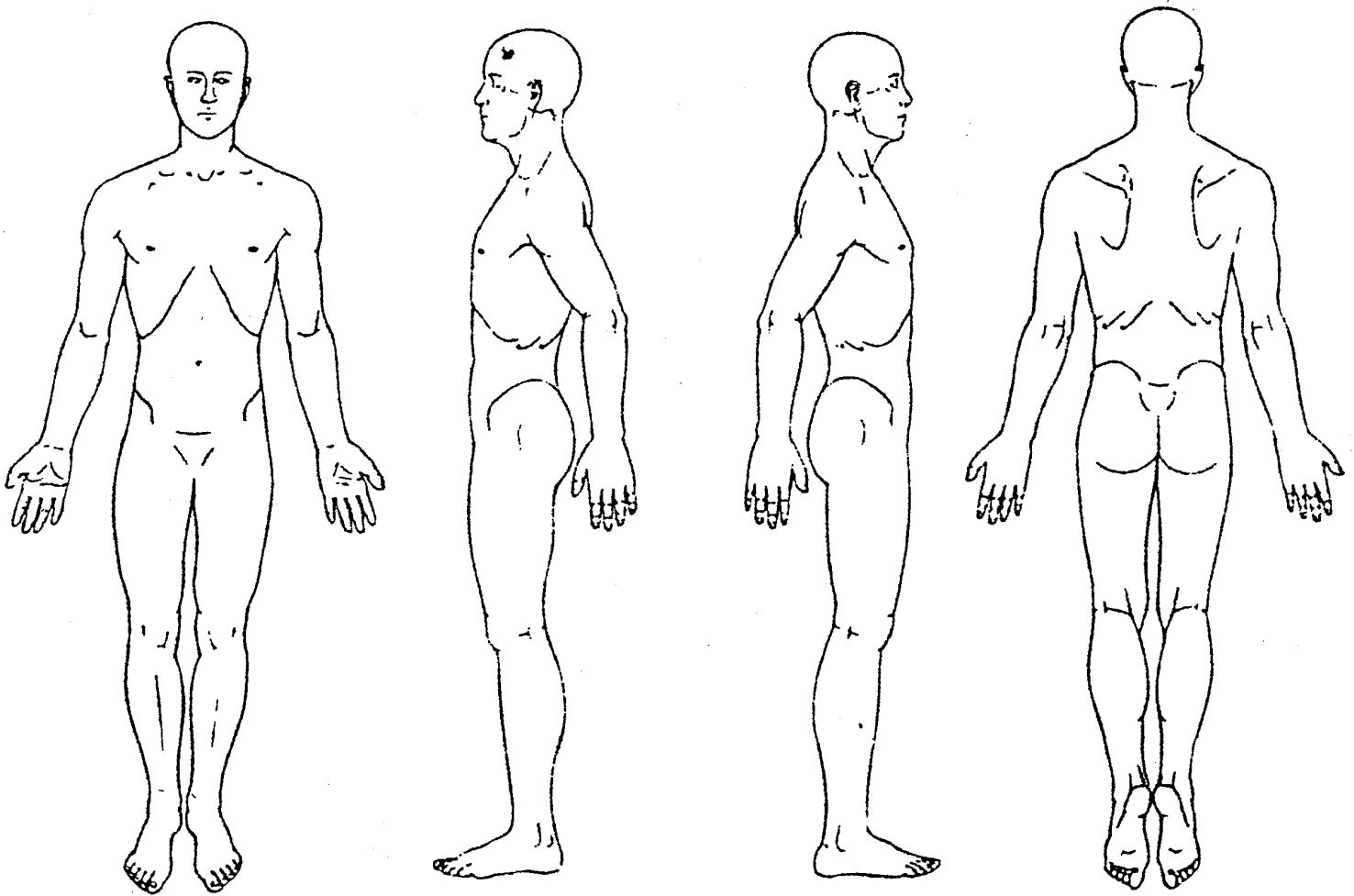
Date: \_\_\_\_\_

\_\_\_\_\_ First Visit

Name: \_\_\_\_\_

\_\_\_\_\_ Follow-up Visit

Please check or circle the areas of your body where you sense pain on the diagrams below.



Next to each area noted above, please indicate pain intensity.

No Pain

Nominal

Tolerable, but  
impedes activities

High - 50% of  
activities impaired

Extreme - most  
activities impaired

Unbearable

0

1

2

3

4

5

6

7

8

9