

Patient: _____ DOB: _____ Today's Date: _____

Injection #: 1 2 3 4 5 6 7 8 9 10

Chief complaints and/or progress: _____

Circle your current pain level (0 indicating no pain and 10 being the worst): 0 1 2 3 4 5 6 7 8 9 10

Patient Signature: _____

PAIN DRAWING

Mark these drawings according to where you hurt. Please indicate which sensations you feel.
///// Stabbing, XXXX Burning, 0000 Pins & Needles, ===== Numbness, ++++ Aching

