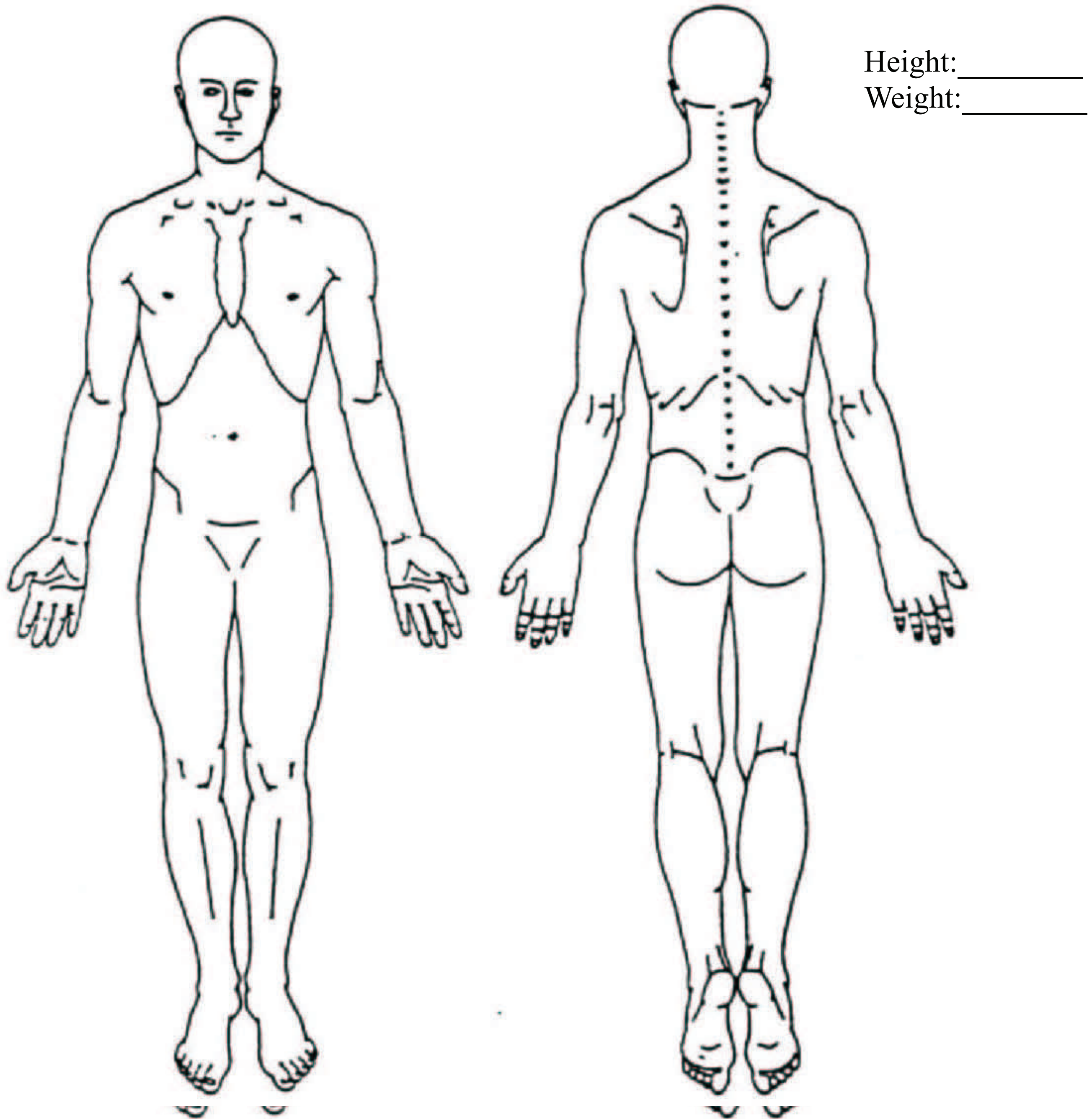
Name______________________________ Date __________________

Patient Pain Diagram

On the body diagram below, please indicate where your pain is located



Pain Scale

0 — 5 — 10

No Pain — Worst Pain Possible

Please rate your pain between the two extremes 0 being no pain at all and 10 being the worst pain you have ever felt.

Current pain ___________ At your Best______________ At your Worst_______________