

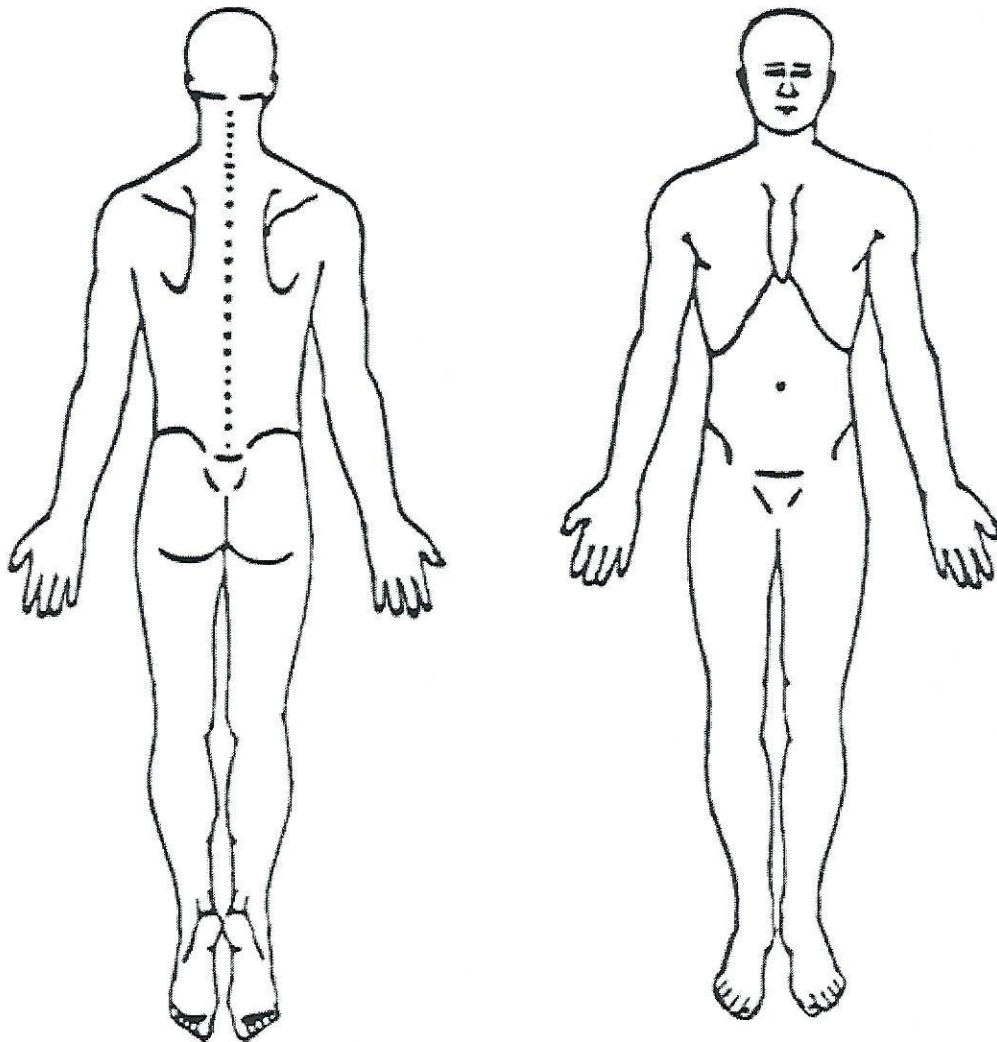
Name: _____

Date: _____

CURRENT SYMPTOMS

Mark The Areas On Your Body Where You Are Having Symptoms From Your **Injury(ies)**. Also, Review The **Pain Scale** On The Bottom Of This Page.

P = Pain **N** = Numbness/Tingling **T** = Tenderness **B** = Burning **R** = Radiating



PAIN SCALE

0-1	=	Minimal	=	The pain is an annoyance but does not stop me from working.
2-3	=	Slight	=	I can tolerate the pain but it causes some difficulty in doing my work. However, it does not stop me from working.
5	=	Moderate	=	The pain causes a marked handicap in my ability to work, but I can continue.
7-8	=	Moderate To Severe	=	The pain is approaching the worst I have ever experienced or could imagine. It causes a significant problem with working and most of the time I can't.
10	=	Severe	=	The pain is the worst I have ever experienced or could imagine and causes me to stop all work and activity.