PATIENT NAME: _____
First MI Last

PAIN DIAGRAM

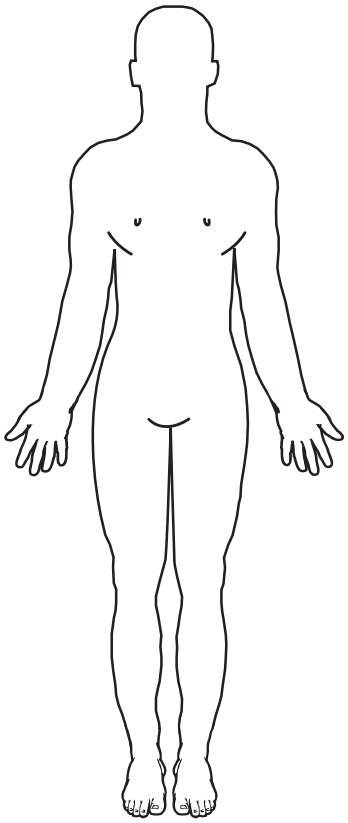
On a scale of 1– to –10, how would describe your pain level when it is at its worse?

No Complaints	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	**Extreme Pain**
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

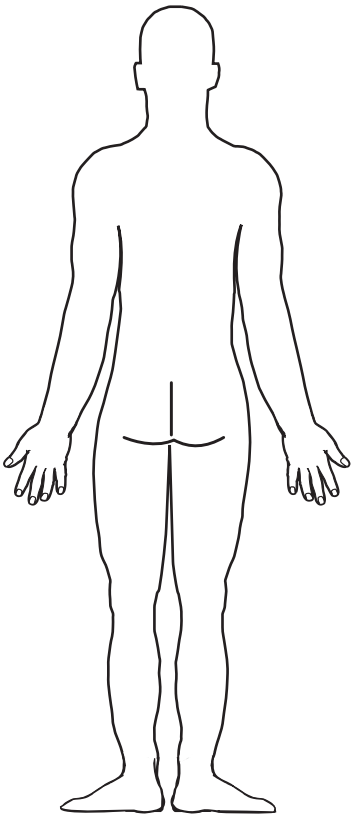
Place an "X" on the area of pain; use the appropriate symbol of other symptoms you feel. If you are being seen for your foot or hand/wrist, use the diagrams at the bottom.

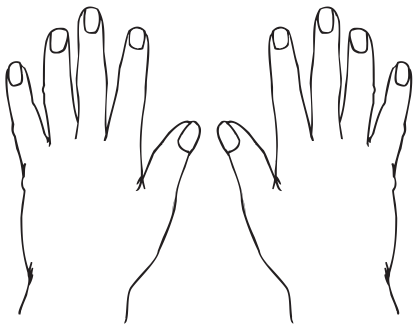
Pain	Aching	Numbness	Pins & Needles	Burning	Stabbing
xxx	¢¢¢	+++	•••	√√√	///

Front View

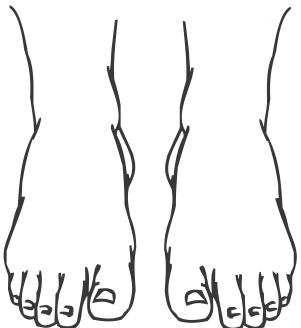


Back View





Left Right



Right Left

_____ _____
Signature Date

_____
Name of Person Completing this Form