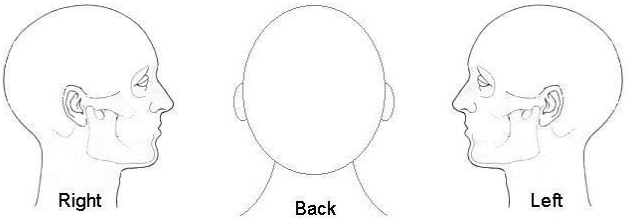
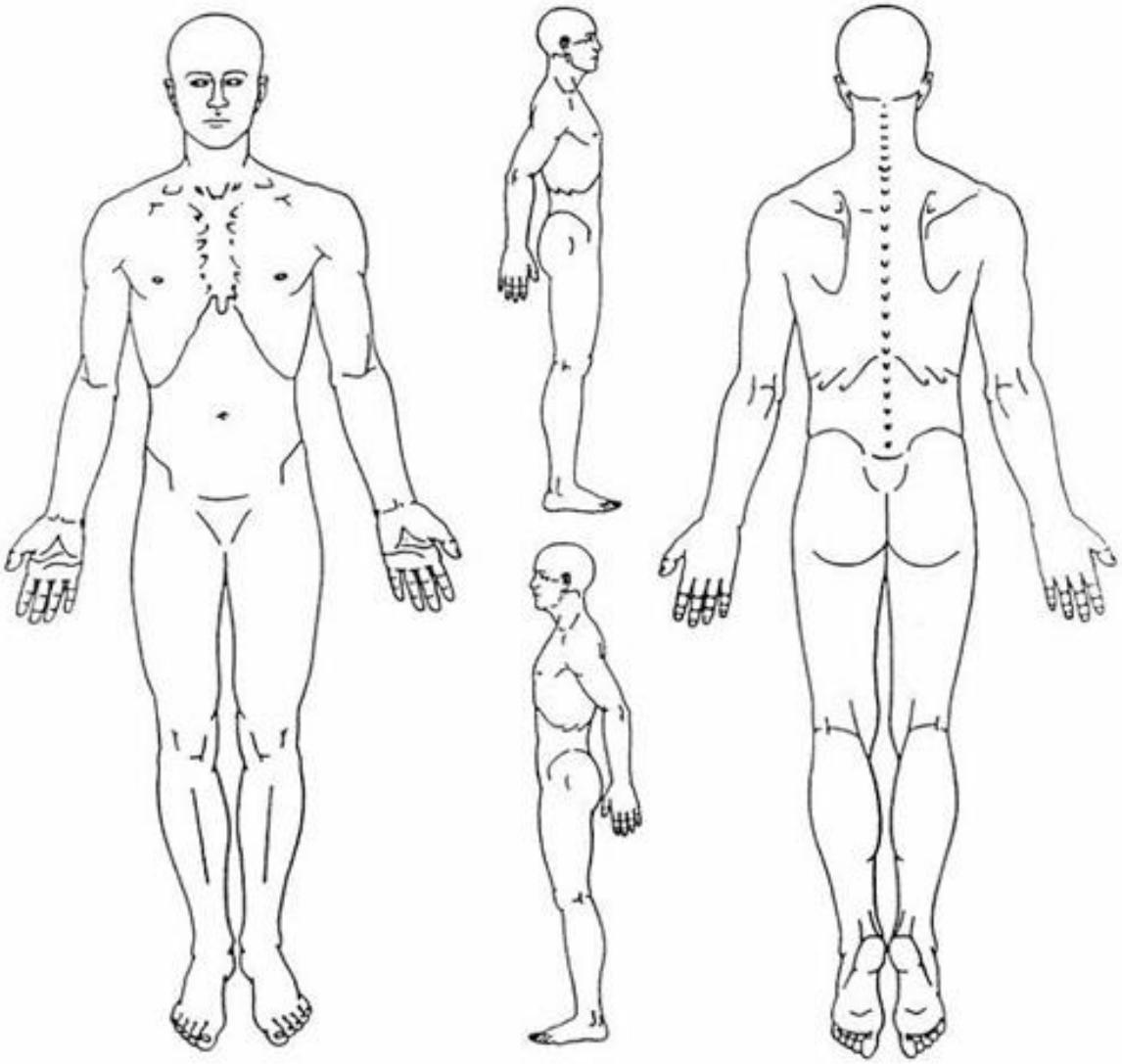
Patient Name_____

Pain Questionaire

How would you describe your pain?:

❑Dull ❑Achy ❑Sharp/Stabbing ❑Burning ❑Tingling ❑Shooting ❑Deep pain

❑Better with rest ❑Worse with rest/nighttime ❑Other _____

What is your pain level? Low 1 2 3 4 5 6 7 8 9 10 High

Please indicate your area(s) of pain: