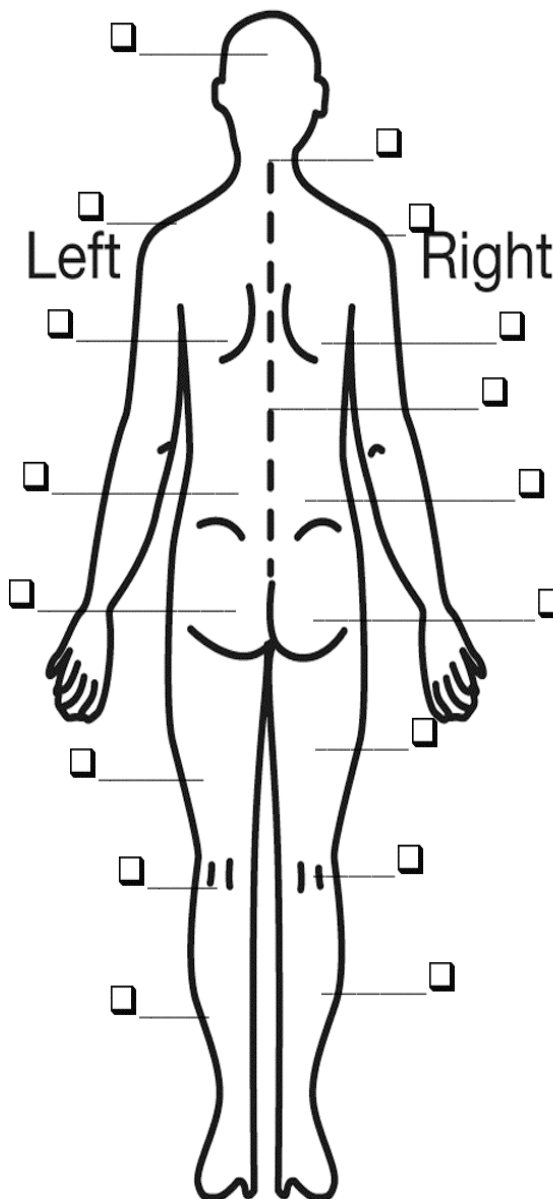
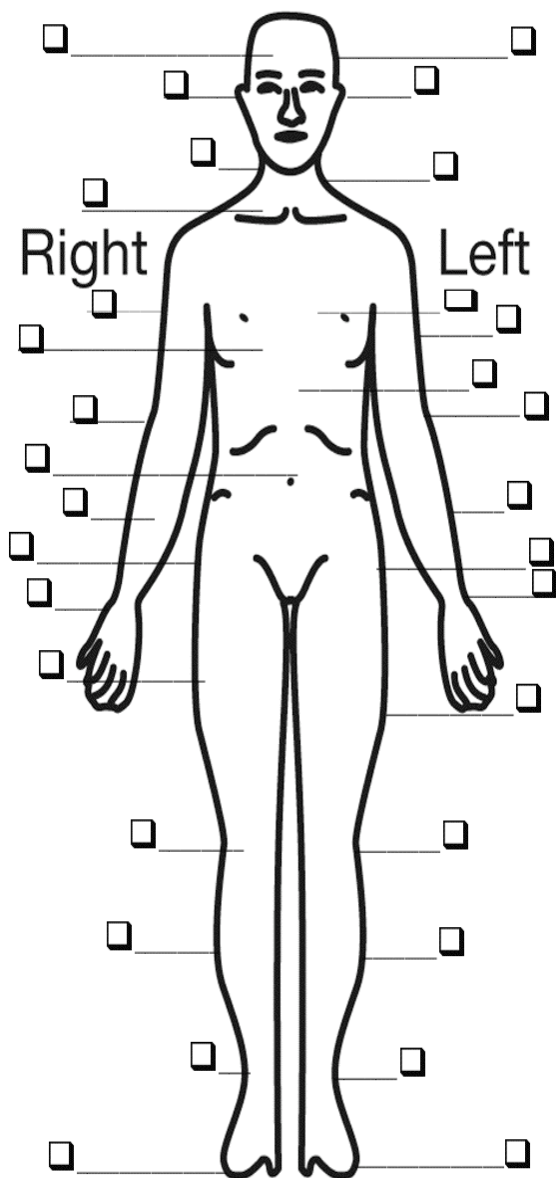


PAIN DRAWING

PATIENT NAME: _____ DATE _____

Using the numbers given below mark the areas on your body where you feel the described sensations. Include all affected areas.

1 Aching 2 Numbness 3 Pins and Needles 4 Burning 5 Stabbing 6 Other





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Pain in arm (s) compared with neck Worse Same Less

Pain in leg (s) compared with back Worse Same Less

Modified McGill Pain Questionnaire

Please pick words that describe your pain. Try and be selective in marking those that apply

- | | | | | |
|-------------------|-------------------------------|-------------------------------|-----------------------------------|---------------------------------|
| Throbbing | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Shooting | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Stabbing | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Sharp | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Cramping | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Gnawing | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Burning | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Aches | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Heavy | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Tender | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Splitting | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Exhausting | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Sickening | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Fearful | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Punishing | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |

Patient Signature

Date