MONTALAND MCGRATH CHIROPRACTIC

Pain Diagram

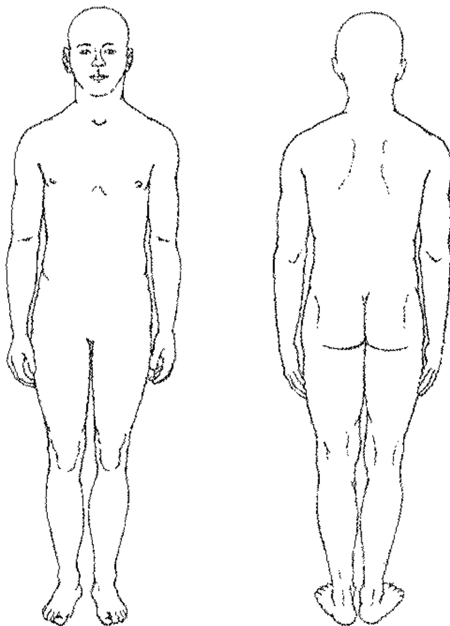
Patient Name:____

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark areas on the body where you feel the described sensations
Use the appropriate symbols
Mark areas of radiation
Include all affected areas

Numbness	**Pins & Needles**	**Burning**	**Aching**	**Stabbing**
…..	ooooo	xxxxx	*****	/////
…..	ooooo	xxxxx	*****	/////
…..	ooooo	xxxxx	*****	/////
…..	ooooo	xxxxx	*****	/////

Please mark on the pain scale from 0 to 10 the pain you feel with this condition.
10 being the worst pain you have felt with this condition.



Neck-Shoulder-Arm-Pain

On a scale of zero to ten, I rate my Discomfort as follows:

(__________________________)
0 10

Mid Back Pain

On a scale of zero to ten, I rate my Discomfort as follows:

(__________________________)
0 10

Low Back and Leg Pain

On a scale of zero to ten, I rate my Discomfort as follows:

(__________________________)
0 10

____________________ ____

Date Signature