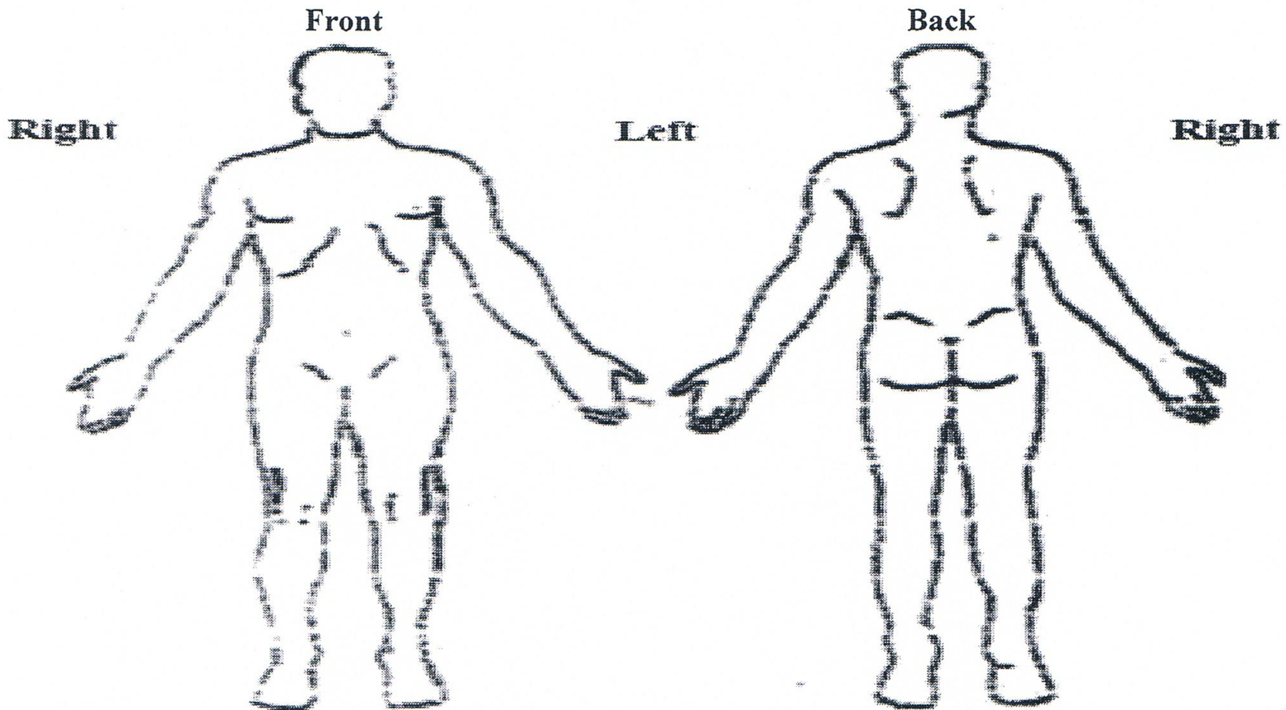
Name: ______________________________

Please use the symbols below to describe the sensation you are experiencing on the diagrams:

Pain: XXX
Ache: OOO
Tightness or stiffness: / / /

Numbness: ^^^
Tingling: - - -



Please circle one of the numbers below for your major complaint: ______________________________

Intensity

0 ____ 1____ 2____ 3____ 4____ 5____ 6____ 7____ 8____ 9____ 10___
None Worst Possible

☐ Always (76% - 100% of the time) ☐ Frequently(51% - 75% of the time) ☐ occasionally (26% - 50% of the time)
☐ intermittently (0% - 25% of the time) ☐ None

Please circle one of the numbers below for your secondary complaint (if applicable): ____________________

Intensity

0 ____ 1____ 2____ 3____ 4____ 5____ 6____ 7____ 8____ 9____ 10___
None Worst Possible

☐ Always (76% - 100% of the time) ☐ Frequently (51% - 75% of the time) ☐ occasionally (26% - 50% of the time)
☐ intermittently (0% - 25% of the time) ☐ None

______________________________ ____________________
Signature Date