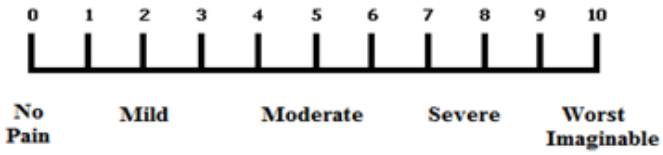
Patient Name:_____ **Date:**_____

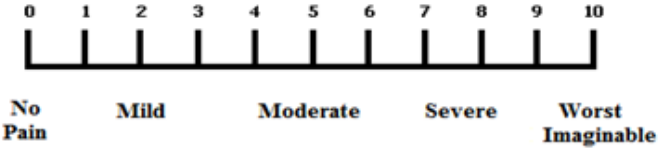
Instructions: Please *circle* the number that best represents the level of pain that you are experiencing *right now.*

PAIN ASSESSMENT

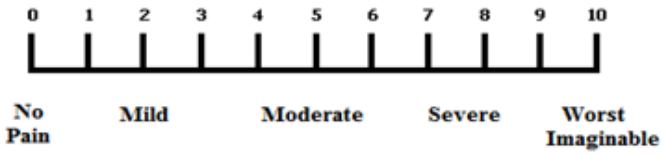
NECK PAIN



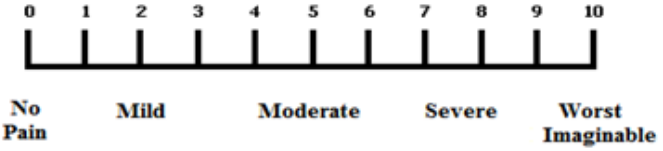
BACK PAIN



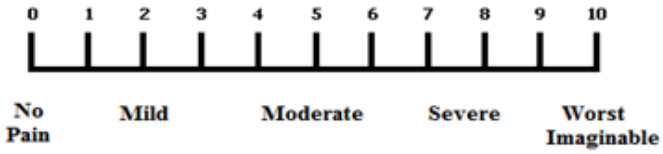
LEFT ARM/SHOULDER PAIN



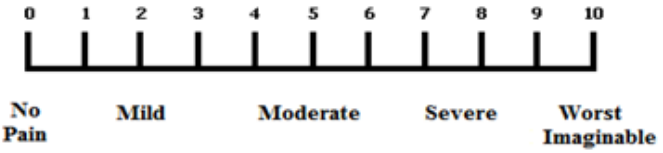
LEFT LEG PAIN



RIGHT ARM/SHOULDER PAIN



RIGHT LEG PAIN



Have you taken any pain medication or muscle relaxers today? □ NO □ YES

Patient Signature:_____ **Date:**_____