GREAT PLAINS THERAPY

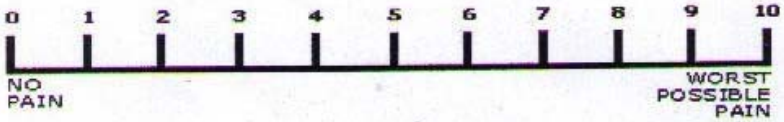
Name_____DOB_____Date_____

Where is your pain?_____
If you have more than one complaint, please ask for a separate form.

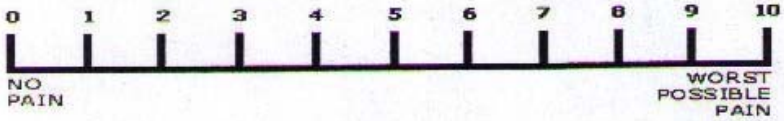
Please circle the number that best describes your pain.

1. What is your pain **RIGHT NOW**?

2. What is your **TYPICAL or AVERAGE** pain?



3. What is your pain **AT ITS BEST**? (How close to "0" does your pain get?)



4. What is your pain **AT ITS WORST**? (How close to "10" does your pain get?)

HOW WOULD YOU DESCRIBE YOUR PAIN?

NUMBNESS

PINS AND NEEDLES

BURNING

STABBING

ACHING

DOES IS RADIATE TO OTHER AREAS?

PLEASE INDICATE PAIN LOCATION