Patient Symptom Sheet

Name: _____

Date: _____

SYMPTOMS

Mark on the line which number represents complaints over the last few days

1. _____

_____

No Pain — Extreme Pain

2. _____

_____

No Pain — Extreme Pain

3. _____

_____

No Pain — Extreme Pain

4. _____

_____

No Pain — Extreme Pain

Indicate areas of pain on drawing.

Put letter around area(s).

A- ache

B- burning

N- numbness

P- pain