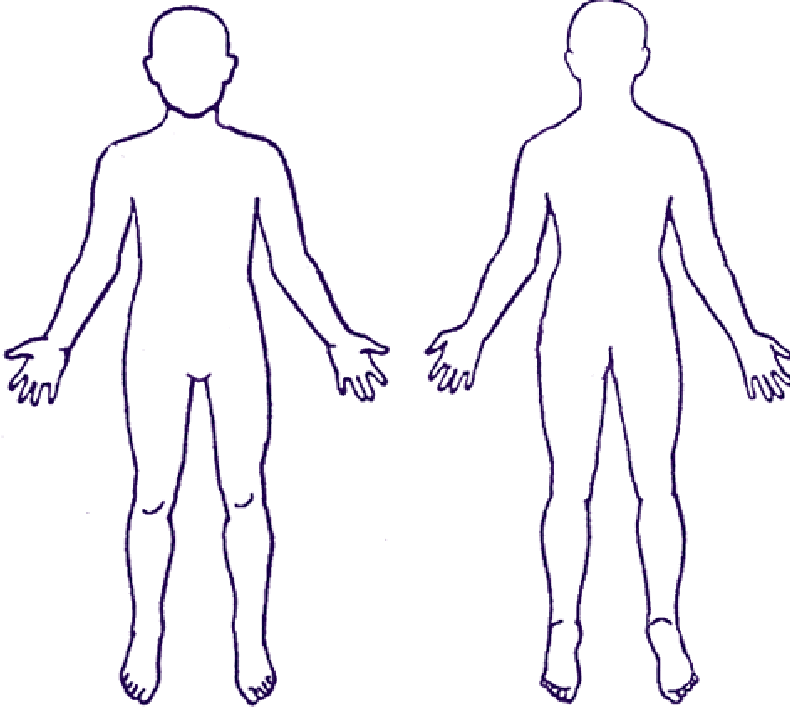
PAIN DRAWING
maXum Therapy

PLEASE MARK AN "X" ON THE FIGURE BELOW IN ALL AREAS WHERE THRE MAY BE PAIN.



Pain and Symptom History:
Please circle your current pain level: 0 being no pain, 10 being excruciating pain.

0 1 2 3 4 5 6 7 8 9 10

(No Pain) (High Pain)

Please describe your pain:
(check all boxes that apply)

☐throbbing ☐tingling ☐burning ☐sore

☐deep ache ☐numb ☐sharp pain

☐shooting ☐weakness ☐other:___________

Check all that apply to the current complaint:

☐dizzines ☐naseau ☐balance problems

☐difficulty walking ☐ringing in ears ☐headaches

Signs associated with your chief complaint:

☐swelling ☐redness ☐warmth ☐bruises

☐muscle atrophy ☐muscle spasm ☐loss of movement

Where did the pain begin:____

Where is the pain now: ____

List the areas from worst to least:____

What activities INCREASE the pain:____

What activities DECREASE the pain:____