

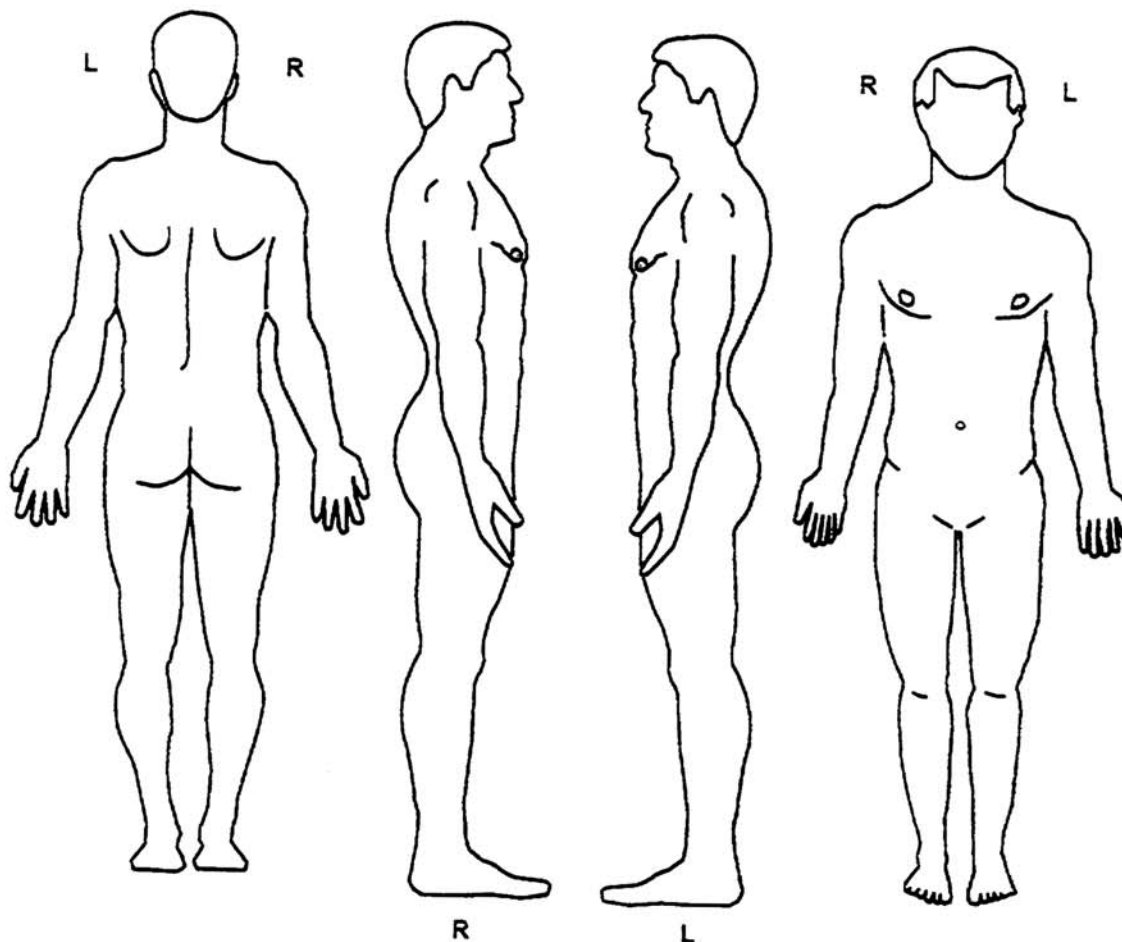
Pain Drawing

Because of your pain, does it **INTERFERE** with any of the following activities of daily living:

- | | | |
|----------------------------------|--|--|
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Working at computer | <input type="checkbox"/> Housework |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Reading/Studying | <input type="checkbox"/> Climbing stairs |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Vacuuming | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Sleep | <input type="checkbox"/> Carry groceries |
| | | <input type="checkbox"/> Take out trash |

Hobbie(list): _____

Date of onset problem/pain? _____



Mark as follows:

A- Ache

B- Burning

N- Numbness

P- Pins and Needles

S- Stabbing

O- other – describe _____

Name: _____

Date: _____