



Pain scale

Name \_\_\_\_\_

Date \_\_\_\_\_

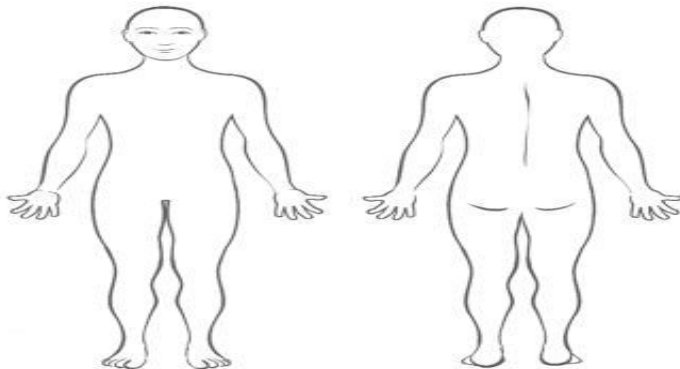
Please explain how the injury occurred. If follow-up please write follow-up.

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Are you taking medication? Yes No



Does the medication help you function better? Yes No

Where is your pain now?



Is there is any numbness or tingling? Yes No. If yes please explain.

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What is your pain scale?  0 1 2 3 4 5 6 7 8 9 10 

**Have you improved? Yes No**

**How much? 10 20 30 40 50 60 70 80 90 100 %**

**Sign \_\_\_\_\_**