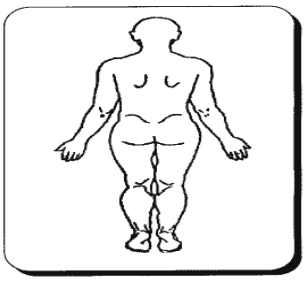
The Orthopedic Center Physical Therapy and Sports Medicine Pain Assessment Questionnaire

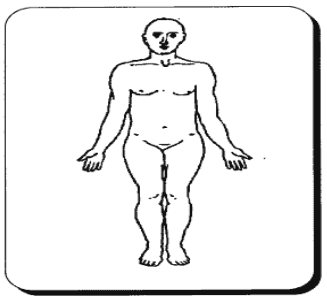


Acct#: _____ Date of Birth: _____ Date: _____

Patient Name: _____

1. What is your pain RIGHT NOW?

   No Pain ----0----1----2----3----4----5----6----7----8----9----10----Worst Pain



   Please use the diagram to the right to indicate where you feel symptoms right now. Use the key below to indicate the different type of symptoms.

   Pins & Needles= 0000 Burning= XXXX Stabbing= //// Deep Ache= ZZZ

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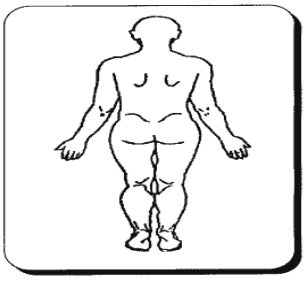

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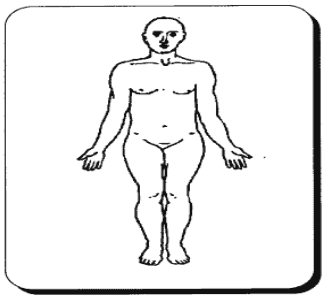
2. What is your pain RIGHT NOW?

   No Pain ----0----1----2----3----4----5----6----7----8----9----10----Worst Pain



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