



Eclectic Physical Therapy  
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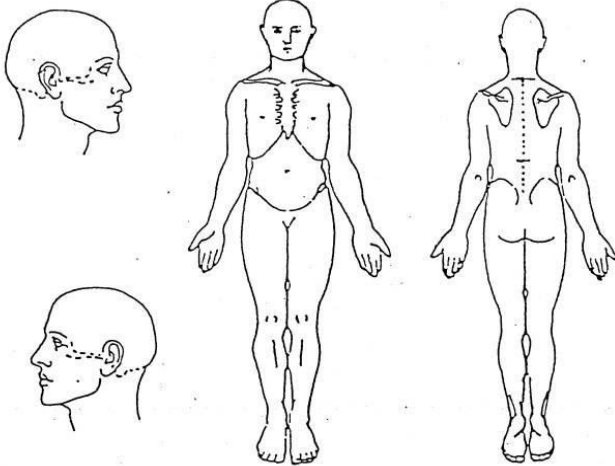
### PAIN ASSESSMENT

Intensity of your pain on scale from 1-10: (0=No Pain; 10=Unbearable Pain):

At rest: \_\_\_\_\_

With movement: \_\_\_\_\_

Mark location of pain:



Onset of your pain: \_\_\_\_\_ Sudden  
\_\_\_\_\_ Gradual

Frequency of your pain: \_\_\_\_\_ Constant  
\_\_\_\_\_ Frequent \_\_\_\_\_ Occasional  
\_\_\_\_\_ Rare

Description of your pain: \_\_\_\_\_ Sharp  
\_\_\_\_\_ Dull \_\_\_\_\_ Throbbing  
\_\_\_\_\_ Burning  
\_\_\_\_\_ Shooting \_\_\_\_\_ Numbness  
\_\_\_\_\_ Tingling \_\_\_\_\_ Localized

\_\_\_\_\_ Widespread

Behavior of your pain: Worse \_\_\_\_\_ Morning \_\_\_\_\_ Afternoon \_\_\_\_\_ Evening \_\_\_\_\_ Nighttime

Does your pain wake you at night? \_\_\_\_\_ Y \_\_\_\_\_ N If yes, \_\_\_\_\_ x/week

What makes your pain/symptoms increase?

What makes your pain/symptoms decrease?

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