Center for Orthopedic and Sports Physical Therapy
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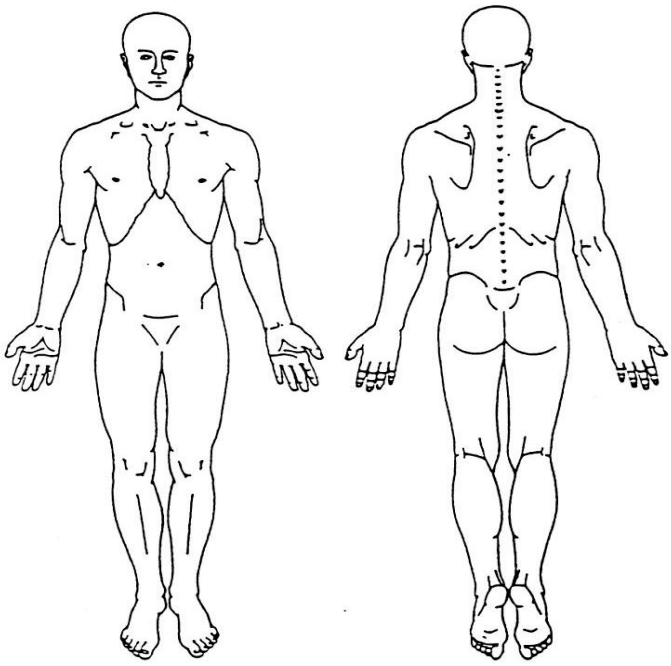
Body Diagram

Date:_____

Patient Name:_____ Date of Birth:_____

On the body diagram below, shade in the area(s) where you are having pain, tingling, or numbness with this episode.



On the 0-10 scale provided below, circle the **average pain level** at this time.

Best _____ **Worst**

0 1 2 3 4 5 6 7 8 9 10

On the 0%-100% scale provided below, circle the **percent of normal function** at which you are currently able to perform. This includes: work performance, activity at home, sports, socially with friends, etc.

Best _____ **Worst**

100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%

Current Medications (for this complaint): _____

_____

_____

_____