Peak Performance Therapy Center
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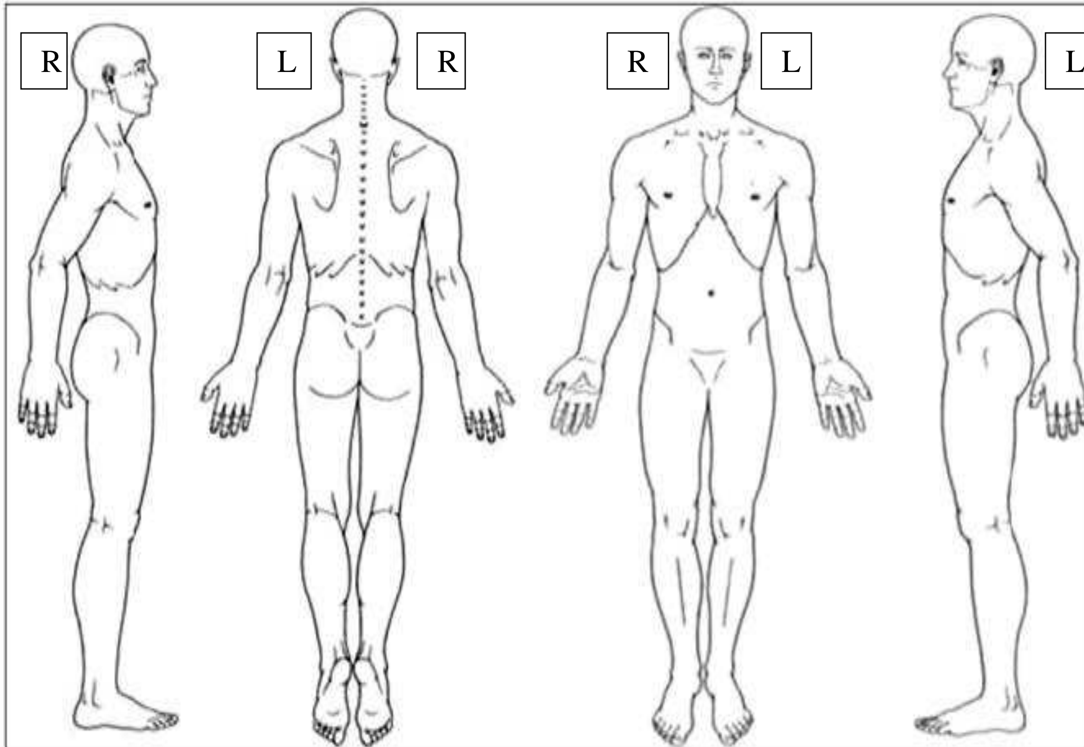
Occupational Therapists
J. Aaron Staeben, OTR/L, CHT
Greg Treece, MS, OTR/L, CHT
Chelsea Christensen, COTA/L

Physical Therapists
Eric Palenik, PT, DPT
Rick Meade, MS, PT, Cert. MDT
Corina Johnson, PTA

PAIN DIAGRAM

PLEASE COMPLETE *ONLY* IF PAIN IS ONE OF THE REASONS YOU HAVE BEEN REFERRED TO THERAPY

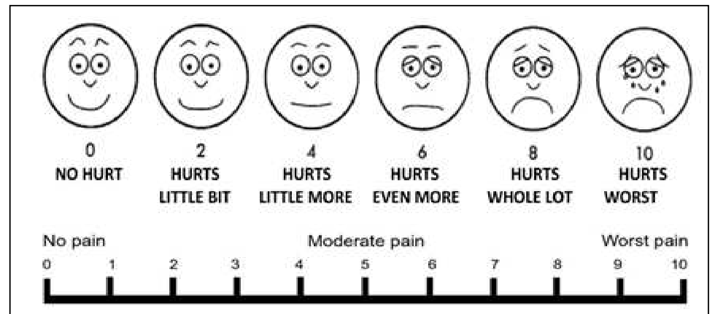
Instructions: Please mark on the drawing below using the key provided to indicate your symptoms.



Stabbing/Sharp	/////
Burning	XXXX
Pins & Needles	OOOO
Numbness	====
Aching/Throbbing	++++

Please answer the following to the best of your ability using the pain scale 0-10:

Your current level of pain_________________________
Your highest level of pain over the last 24 hours_______
Your lowest level of pain over the last 24 hours________



What activities increase your pain?
____

What activities decrease your pain?
____

Does your pain ever wake you up at night? □ Yes □ No
Have you had similar symptoms in the past? □ Yes □ No, If Yes, explain: ____________________________
____

Patient name:_________________________________ Date: __________________