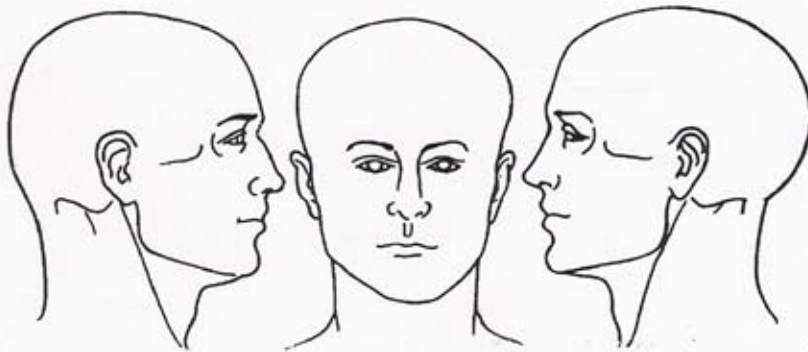
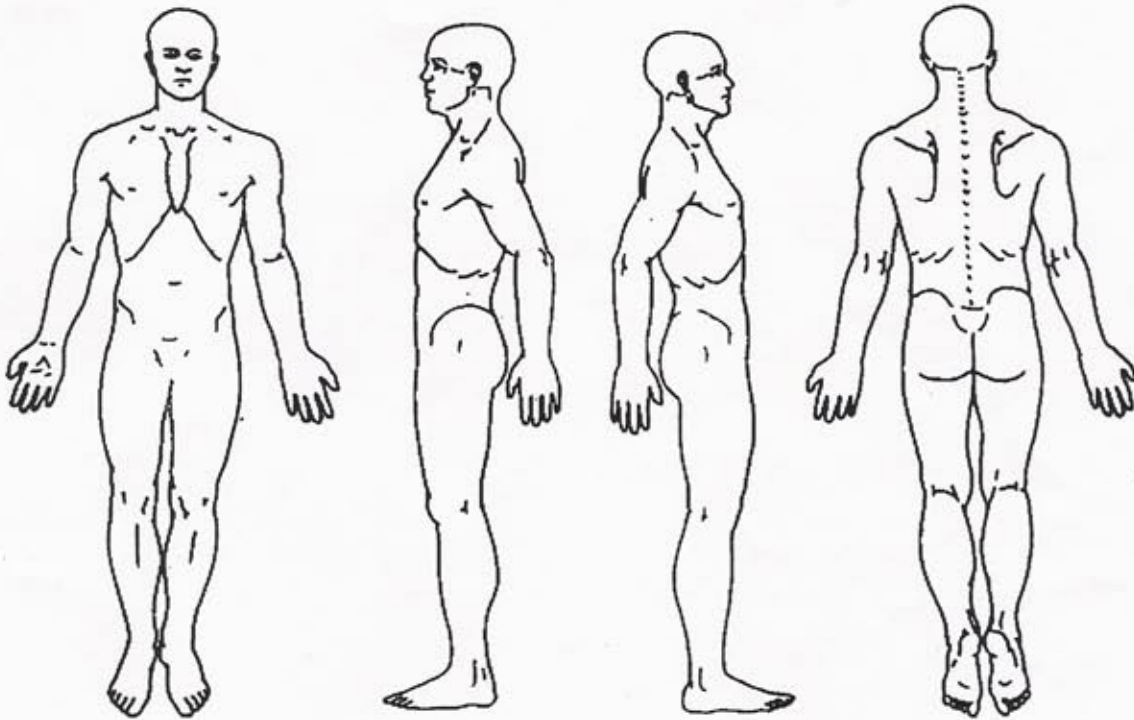


Capital City Health Care Providers, Inc.

Name: \_\_\_\_\_

Chart #: \_\_\_\_\_

Date: \_\_\_\_\_



SENSATION	SYMBOL
Sharp	XXXX
Burning	++++
Ache	////
Pins & Needles	OOOO
Numb	●●●●

**Where does it hurt?** → Mark on the body diagram, where you are hurting today or in the last 2 weeks.

**How does it feel?** → Use the chart above to show how your pain feels.

**How much does it hurt?** → Put a number between 1 and 10 on each of the places where you hurt. "10" would be the worst pain you have ever had or can imagine.

JLA1/98

Reviewing Provider's Signature: \_\_\_\_\_