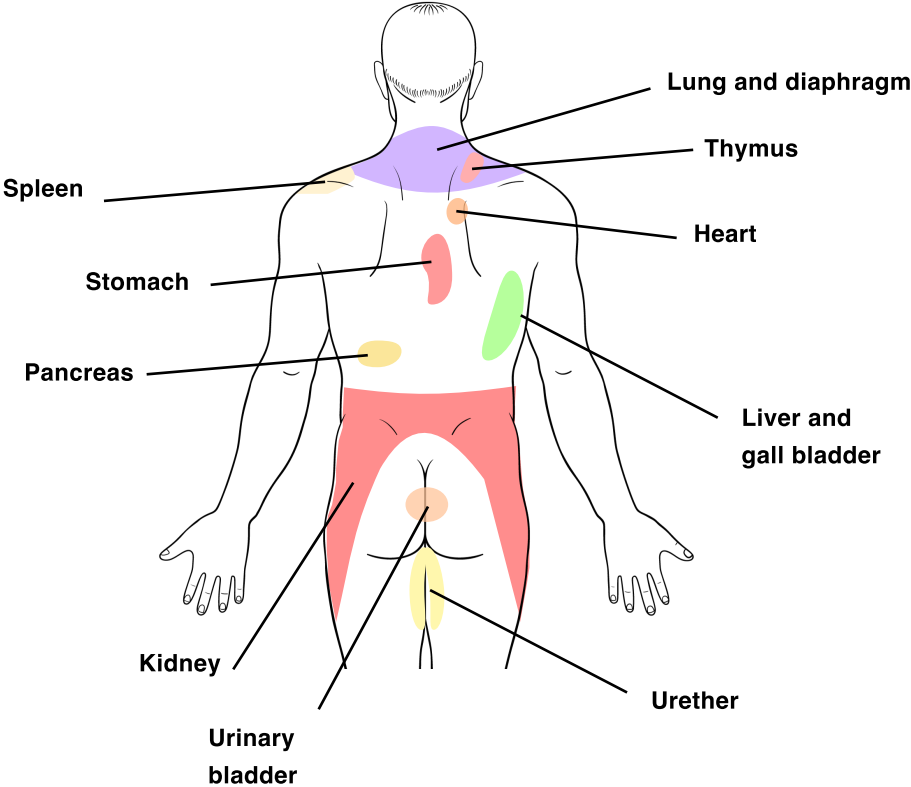


Back Pain Location Chart

Patient Information

Name: _____

Medical Record Number: _____ Date of Assessment: _____



Pain Location: _____

Date of Pain Onset: _____ Duration of Pain: _____

Rate the pain on a scale of 1 to 10, with 1 being the lowest and 10 being the highest: _____

Other symptoms (if any):

Additional comments (if any):