Claims | Claims Management of Missouri, LLC
Mgmt of MO

INJURED WORKER - PAIN CHART

Injured Worker / Employee Name: _____

Employer Name: _____

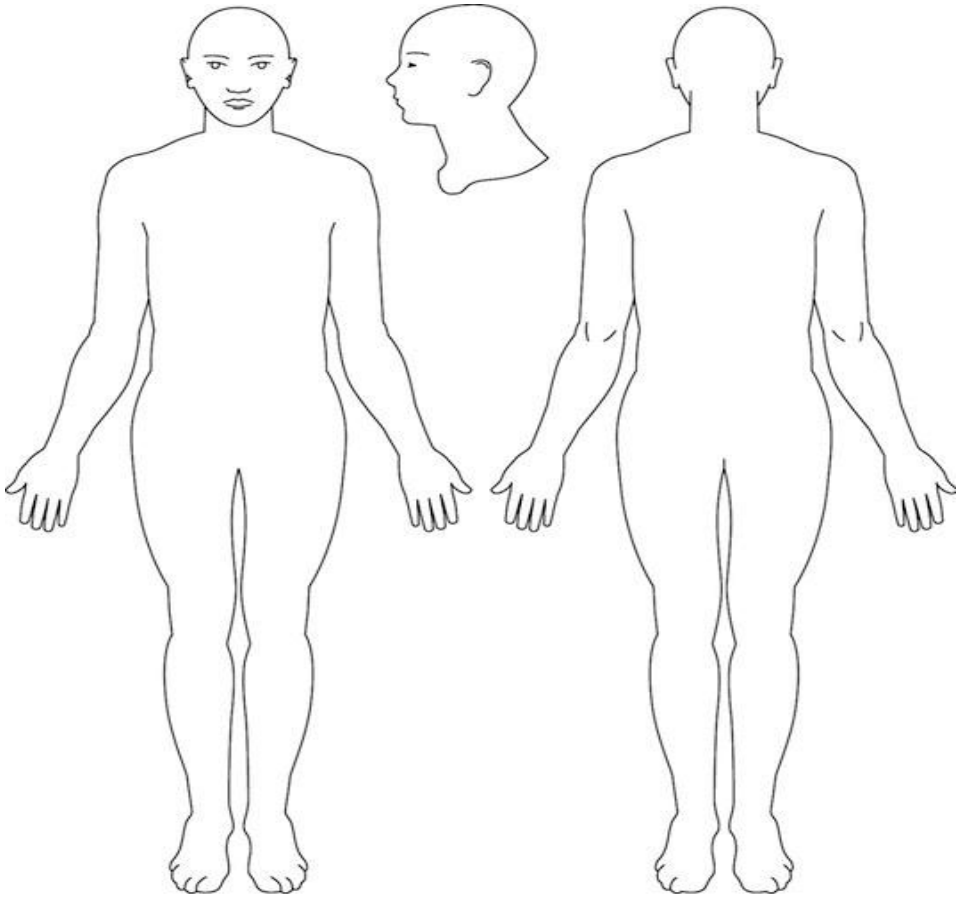
Date of Accident / Injury: _____

Please circle all that apply:

My pain is worse: A) in the morning B) during the day C) at night D) constant E) with activity F) during rest

On a Scale of 0 (no pain) to 10 (unbearable pain requiring hospitalization) - please rate your pain:

At its BEST: _____ **At its WORST:** _____



USING THE KEY PROVIDED, PLEASE DRAW THE SYMBOL REPRESENTING YOUR PAIN OVER THE AREA OF THE BODY AS IT RELATES TO YOUR PRESENT CONDITION.

KEY:

^^^^ = Radiating Pain
xxx = Spasms
zzz = Tenderness
///// = Numbness / Tingling
0000 = Ache / Pain

Injured Worker / Employee Signature: _____

Date: _____