

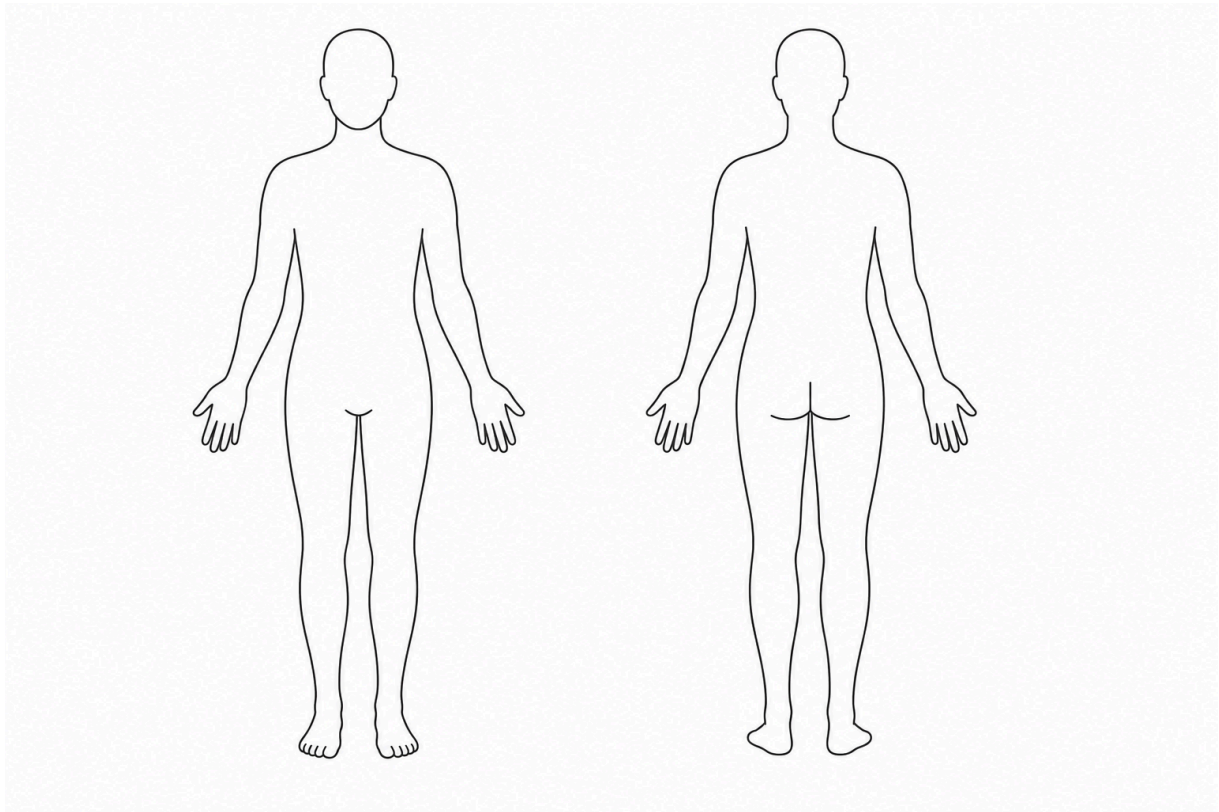


# Body Diagram

Shade or mark the areas where you feel pain, pressure, or discomfort.

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

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Front

Back

**Pain type – circle all that apply:**

- Aching     Burning     Pressure     Stabbing / sharp     Cramping     Other: \_\_\_\_\_

**WHEN IS PAIN WORST?**

- Morning     Evening     After eating     After activity     During / after intercourse     When sitting     No clear pattern
- Other: \_\_\_\_\_

**ADDITIONAL NOTES FOR YOUR PROVIDER**



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