

Visual Pain Scale

Please rate the severity of your pain by circling a number below:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

PLEASE INDICATE THE PAINFUL AFEAS OF YOUR CURRENT SYMPTOMS

Instructions:

- Draw each area of your pain or symptoms onto the chart below
- Choose the number and letter from the lists below to describe your symptoms
- Put the date each area of symptom started for this episode to the best of your knowledge

Please note the words that my help:
(Use all words that apply)

1- Sharp	7- Ache
2- Shooting	8- Tingling
3- Burning	9- Numb
4- Dull	10- Heavy
5- Throbbing	11- Tight
6- Pulling	12- Stabbing

Please note the words that describe your pain
may help describe the symptoms:

A- Constant (never goes away)
B- Intermittent (relieved with position or rest)
C- Occasionally (Daily of less frequent)
D- Infrequent (Once a week)
E- Variable (Comes and goes)

Example:

Please mark the areas of your symptoms:

