SHIPPENSBURG
PHYSICAL THERAPY & SPORTS MEDICINE

Visual Pain Scale

Name:_____

Please rate the severity of your pain in the last 24 hours by (circling) a number below:

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

PLEASE INDICATE THE PAINFUL AREAS 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 at each area of symptom started for this episode to the best of your knowledge

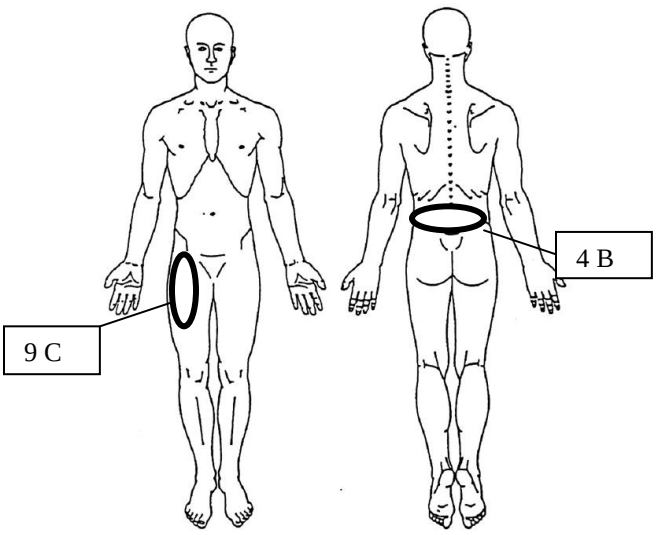
Please note the words that may help describe your pain:
(Use all words that apply)

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

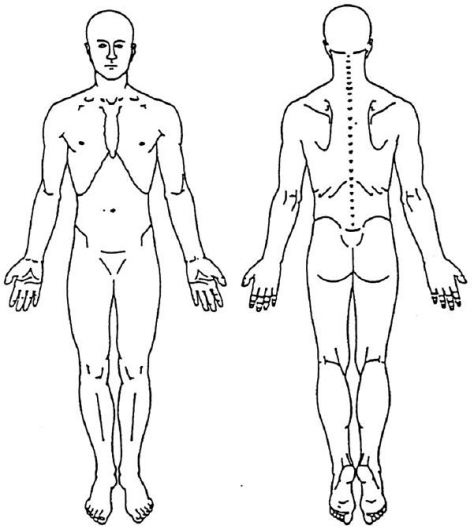
Please note the frequency of your pain to describe the symptoms:

A- Constant (never goes away)
B- Intermittent (relieved with position or rest)
C- Occasionally (daily or less frequent)
D- Infrequent (once a week)
E- Variable (comes and goes)

Example:



Patient:



Signature: _____ Date:_____