Patient Name: _____

Date: _____

Pain Scale Form

Please indicate (by circling the appropriate number) your average pain level last week.

1 2 3 4 5 6 7 8 9 10

NO PAIN WORST PAIN

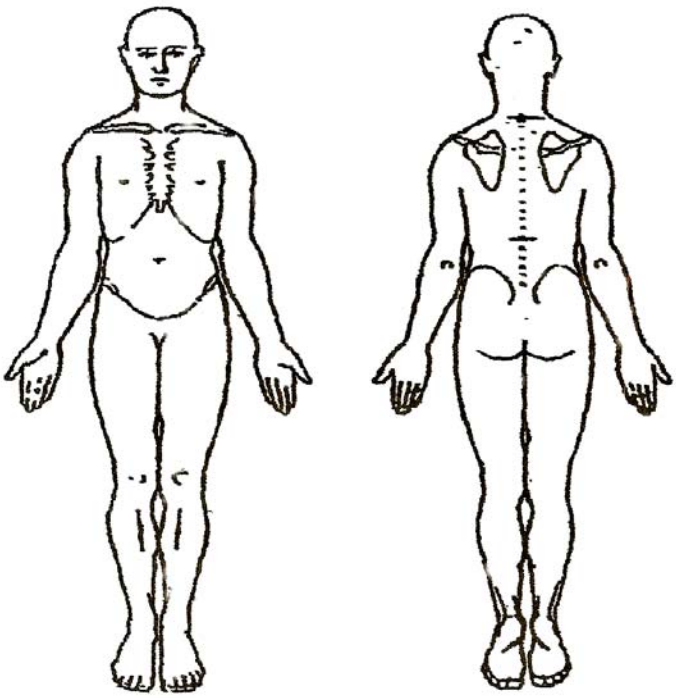
Is the pain you are experiencing (Please Circle)

Constant Intermittent/Comes & Goes

Please Describe the Pain You Are Experiencing In Your Own Words
Examples: Sharp, Ache, Throbbing, Burn, Dull etc…….

Where Is Your Pain?

Please mark on the drawings below where you feel your pain



Body Chart – Draw in where you feel the pain lately
Draw lines for shooting pains and shade in all other pain areas