



BIG SPRING

Physical Therapy & Sports Medicine

Visual Pain Scale

Patient Name: _____ Date: _____

Please relate 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 AREAS OF YOUR CURRENT SYMPTOMS

Instructions:

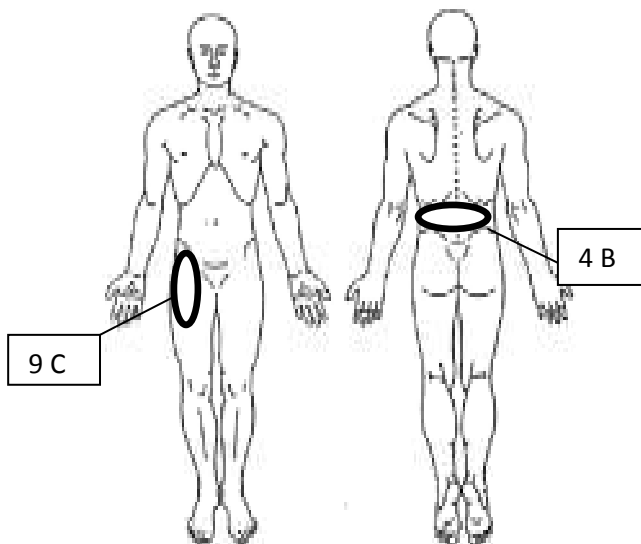
- Draw each area of your pain or symptoms onto the chart below.
- Choose the number and letter from the lists below to describe your symptoms.
- Put the date each area of symptom started or this episode to the best of your knowledge

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

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

1- Sharp	7- Ache	A- Constant (Never goes away)
2- Shooting	8- Tingling	B- Intermittent (Relieved with position or reset)
3- Burning	9- Numb	C- Occasionally (Daily or less frequent)
4- Dull	10- Heavy	D- Infrequent (Once a week)
5- Throbbing	11- Tight	E- Variable (Comes and goes)
6- Pulling	12- Stabbing	

Example:



Please mark the areas of your symptoms:

