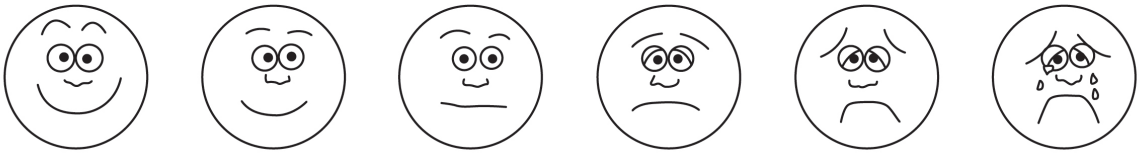
PAIN SCALE

Name: _____ Date: _____

Current Pain Description - circle any that apply

Type of pain : Sharp / Burning / Aching / Tingling / Numbness / Other : _____
Rate your pain (average) on a 1-10 scale (1 = minimal 10 = severe) Pain Level : 0 1 2 3 4 5 6 7 8 9 10



0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

_____
Therapist Signature