Universal Health & Rehabilitation

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NAME_____ DATE_____

Please tick any of the words that describes your pain under the column that describes it's intensity.

	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Cramping				
Gnawing				
Hot-Burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring-Exhausting				
Sickening				
Fearful				
Punishing-Cruel				

Your Pain is:

On Most Days ..... No Pain / Discomforting / Horrible — Mild / Distressing / Excruciating

At It's Worst..... No Pain / Discomforting / Horrible — Mild / Distressing / Excruciating

At It's Best. ..... No Pain / Discomforting / Horrible — Mild / Distressing / Excruciating

TODAY No Pain / Discomforting / Horrible — Mild / Distressing / Excruciating

How many hours of the day are you in pain? .....
How many days per week are you in pain? .....
How many weeks per year are you in pain?.....
What Drugs Have You Taken Today? .....

.....

Your Pain Today - Tick along scale below .

No Pain [_____] **Worst Possible Pain**

PLEASE DRAW YOUR PAIN

xxx	Burning	– –	Numbness
!!	Stabbing	**	Cramping
00	Aching	##	Other