Pain Chart

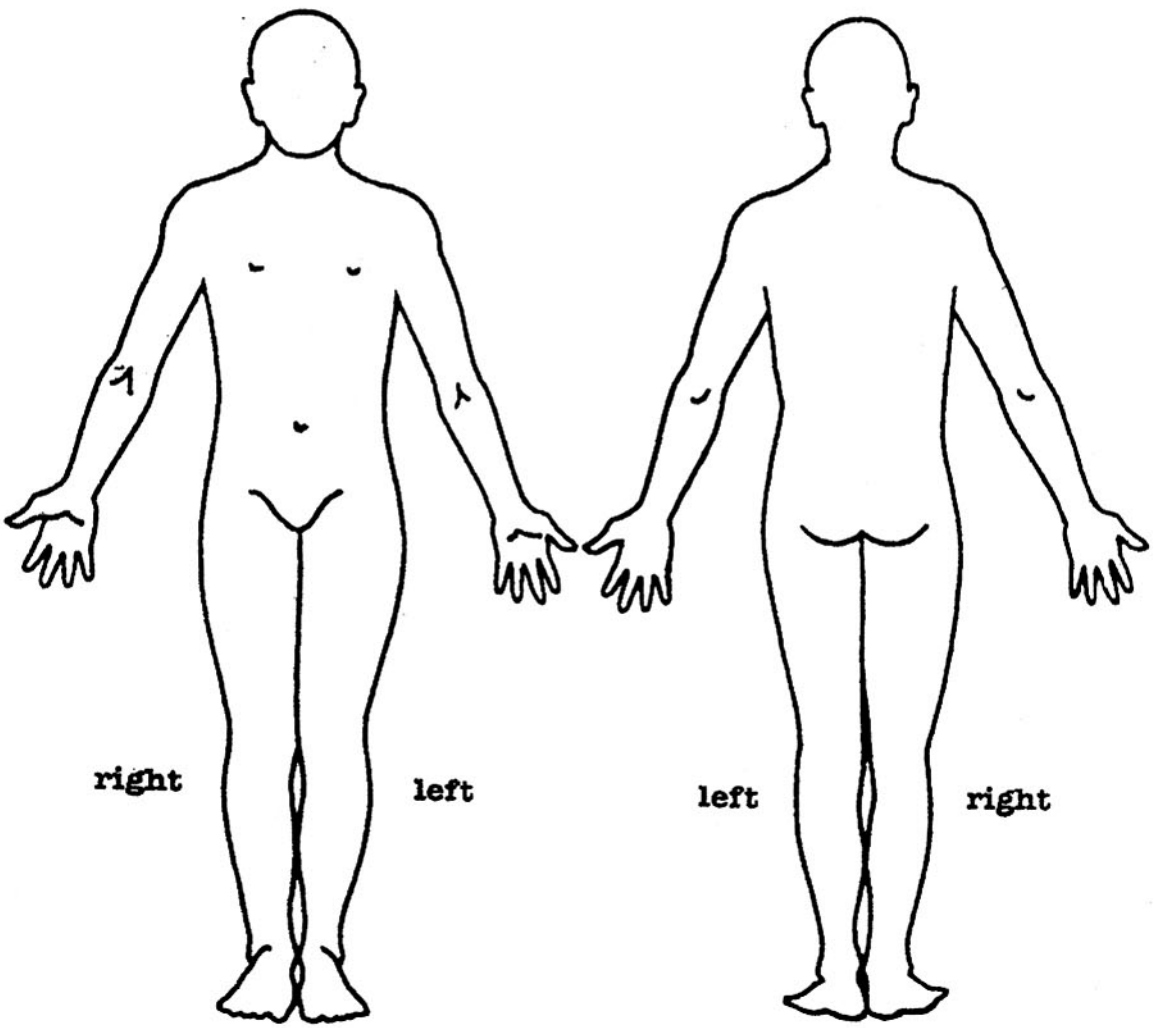
Patient Name: _____

Visual Analogue Scale: On a scale of 1 to 10, 10 being the absolute worst pain imaginable, please mark an X where you feel your pain level is at this moment.

1 _____ **10**

(No Pain) **(Worst Pain)**

Please show the area(s) of pain or unusual feeling :
Mark the areas on the body where you feel pain.



Patient's Signature: _____ **Date:** _____