Success Physical Therapy and Balance Center

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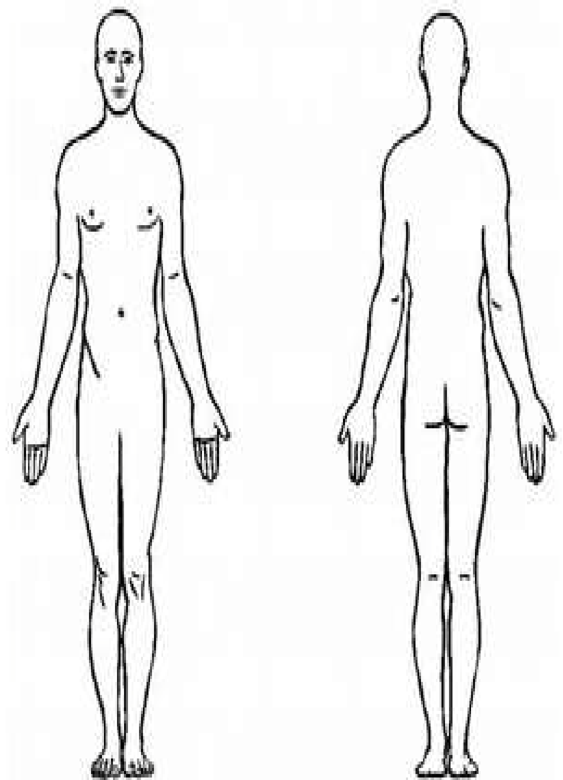
Patient Name: ____ Date:______________________

Check the column to indicate the level of your pain for each word.
Check NONE if it does not apply to you.

	NONE	MILD	MODERATE	SEVERE
Throbbing	______	______	______	______
Shooting	______	______	______	______
Stabbing	______	______	______	______
Sharp	______	______	______	______
Cramping	______	______	______	______
Gnawing	______	______	______	______
Hot/ Burning	______	______	______	______
Aching	______	______	______	______
Heavy	______	______	______	______
Tender	______	______	_____	______
Splitting	______	______	______	______
Tiring/ Exhausting	______	______	______	______
Sickening	______	______	______	______
Fearful	______	______	______	______
Cruel/ Punishing	______	______	______	______



On the above figures, please mark or comment where you are having your pain.

Please mark the line below to indicate how you would rate your pain. The left end of the line means no pain at all and the right end of the line means the worst pain possible.

No Pain Worst Possible Pain

|____|

S /33	**A** /12	**VAS** /10