

Pain Scale

Name _____ Date _____

Please mark a vertical line on the lines below representing how severe the pain is.

(For example) _____
(Absent) (Severe)

Rate the pain you have right now:

_____ (Absent) (Severe)

Rate your pain at it's best in the past week:

_____ (Absent) (Severe)

Rate your pain at it's worst in the past week:

_____ (Absent) (Severe)

Rate your average pain in the last week:

_____ (Absent) (Severe)