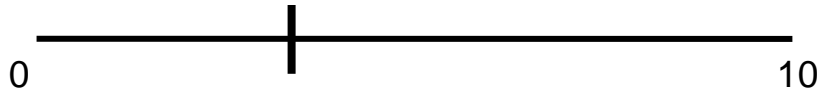


Pain Rating using the "Visual Analog Scale"

Please complete this form when you arrive for your appointment

Zero (0) at the left side of the page, indicates no pain at all. Ten (10) at the right side of the page indicates pain that is unbearable. Please make a single vertical mark on each line at the position that best indicates the amount of pain you feel. For example:



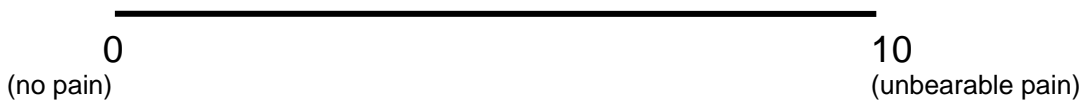
at its WORST in the past 24 hours:



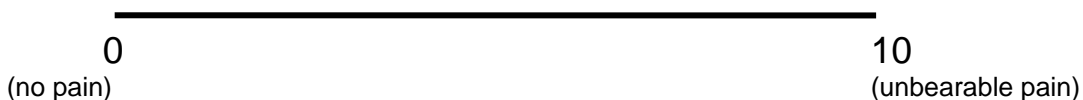
at its LEAST in the past 24 hours:



AVERAGE:



RIGHT NOW:



Are you currently taking medication to help manage your pain? Y N

If Yes, do you know what type of medication and what dosage are you using?

"Over the counter" medication:

Aspirin Tylenol Strength (i.e. mg/tablet) _____


Ibuprofen Other: _____ # tablets per day: _____

Anacin # tablets per day: _____

Prescription medication: _____

Strength (i.e. mg/tablet) _____ # tablets per day: _____

Date: _____

 Patient **OR** Parent/Guardian Signature: _____ 

Scored by: _____

Chart #:

Therapist Initial: _____