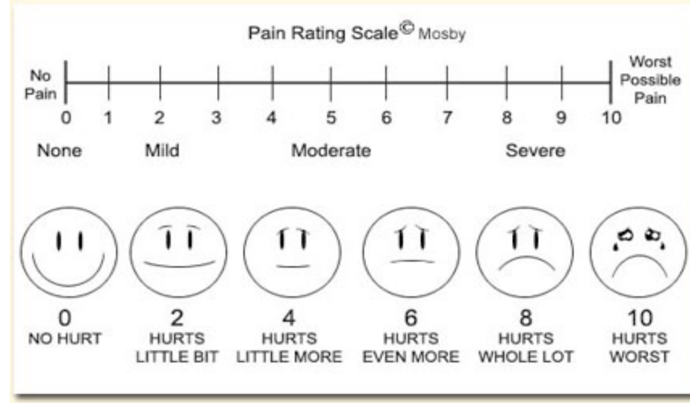
Divine
Therapy & Wellness, LLC.
Striving for Excellence in Rehabilitation Care

Divine Therapy & Wellness, LLC.
3300 SW 34th Ave. Suite 124B
Ocala, FL 34474
Phone: (352) 562-7772
Fax: (321) 400-1422
Toll Free: 1-877-658-1433
E-Mail: PT@divinetherapyandwellness.com
www.divinetherapyandwellness.com

PAIN SCALE

Name:____**Date:**__________

Please rate your pain on the following three scales by assigning a number to your pain intensity. Use the upper line to describe your pain level right now. Use the other two lines to rate your pain at worst and at best over the past 24 hours.



RATE YOUR PAIN 0 = NO PAIN 10 = EXTREMELY INTENSE

Right Now

____

0 1 2 3 4 5 6 7 8 9 10

At Worst

____

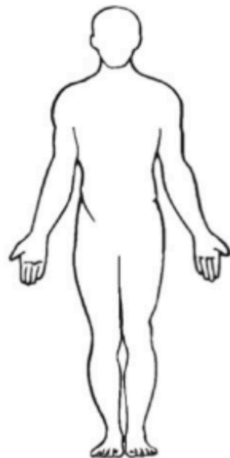
0 1 2 3 4 5 6 7 8 9 10

At Best

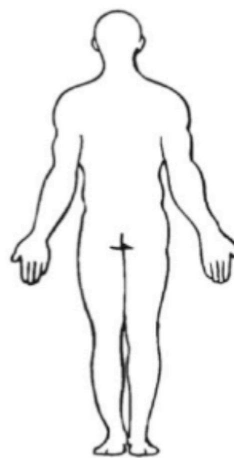
____

0 1 2 3 4 5 6 7 8 9 10

Please use the diagram below to indicate the location of your symptoms. Mark area(s) of pain with an X.



Front



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