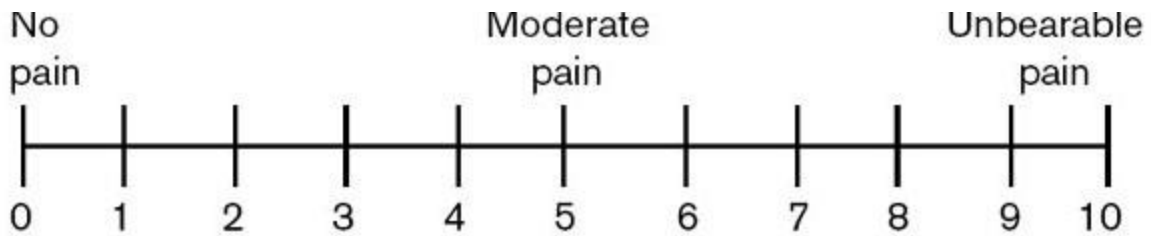




**PELVIC & ORTHOPEDIC**  
**PHYSICAL THERAPY SPECIALISTS**

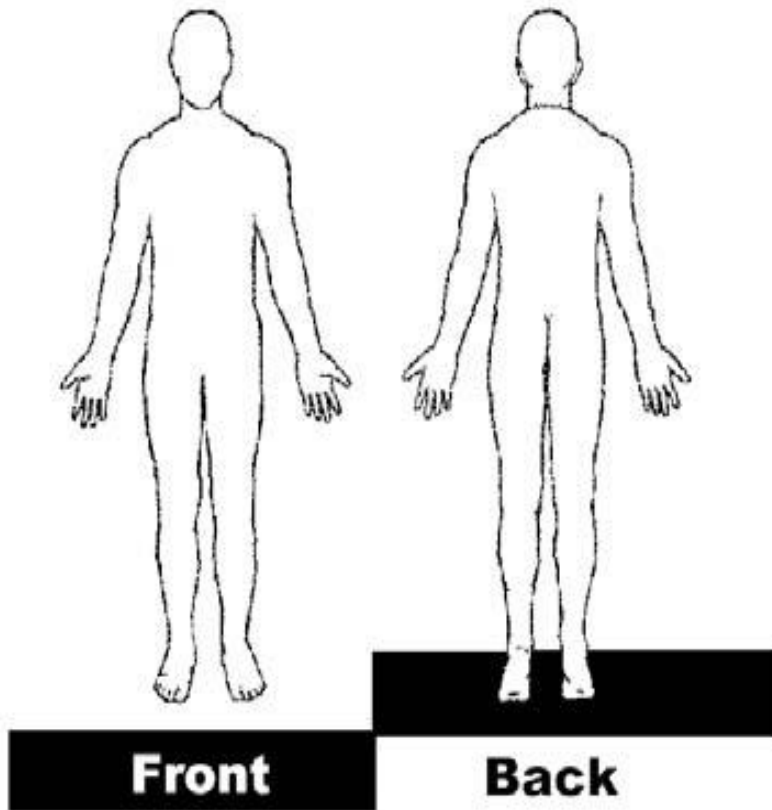
**VISUAL PAIN SCALE**

Please mark the number on the line that corresponds to your current level of pain



**PAIN BODY MAP**

Please indicate the location of any and all current pain and/or irritation on the body diagrams below



Patient Name \_\_\_\_\_ Date \_\_\_\_\_