

**Patient Name:** \_\_\_\_\_

**Area of Pain:** \_\_\_\_\_

Rate the severity of your pain by checking one box on the following scale.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Unbearable Pain

Today's Date: \_\_\_\_\_ Initial: \_\_\_\_\_

Rate the severity of your pain by checking one box on the following scale.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Unbearable Pain

Today's Date: \_\_\_\_\_ Initial: \_\_\_\_\_

Rate the severity of your pain by checking one box on the following scale.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Unbearable Pain

Today's Date: \_\_\_\_\_ Initial: \_\_\_\_\_

Rate the severity of your pain by checking one box on the following scale.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Unbearable Pain

Today's Date: \_\_\_\_\_ Initial: \_\_\_\_\_

Rate the severity of your pain by checking one box on the following scale.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Unbearable Pain

Today's Date: \_\_\_\_\_ Initial: \_\_\_\_\_