PLEASE

SHADE

IN

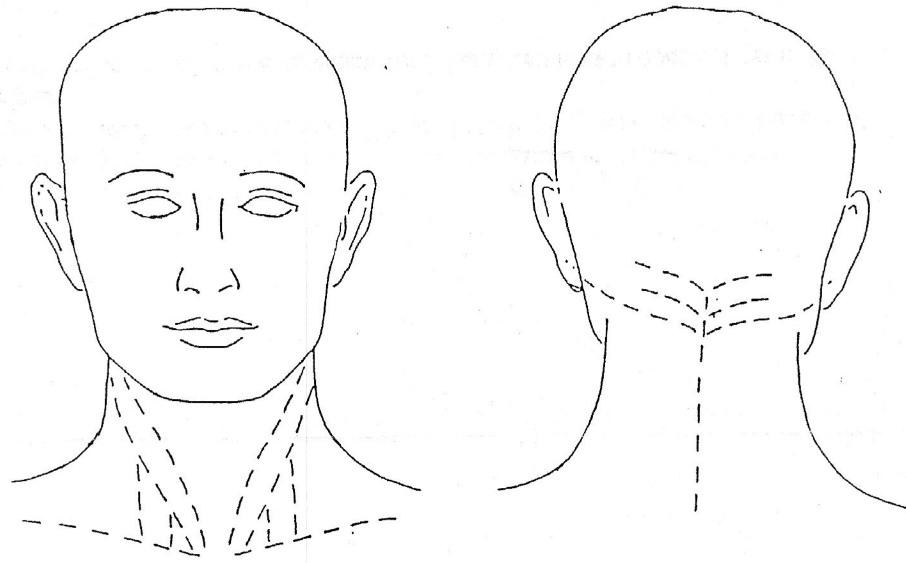
THE

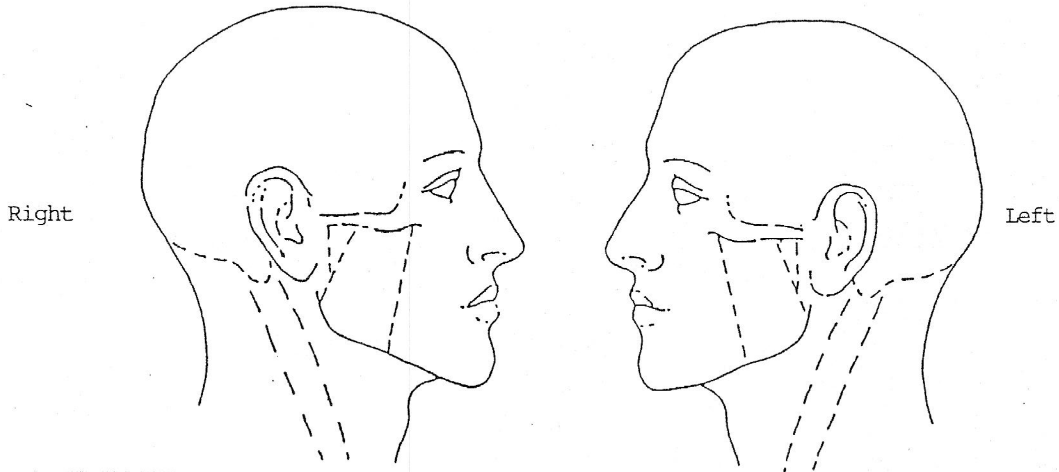
AREAS

YOU

HAVE

DISCOMFORT





Please indicate pain range by circling your **high** and **low** levels experienced within the last month.

10	**EMERGENCY SITUATION** (i.e. having to go to the hospital)
9	**INTENSE**
8	May require frequent use of prescription pain medications, anti-inflammatory and/or
7	muscle relaxants. Activity may be very limited.
6	**MODERATE**
5	Possible use of muscle relaxants, prescription or over-the-counter pain medications.
4	Activity may be limited, but functional for family, work, and social roles.
3	**LOW**
2	Little or no pain medications. Normal levels of activity, except heavy types.
1	
0	**NO PAIN**

Name: ______________________________ Date: __________