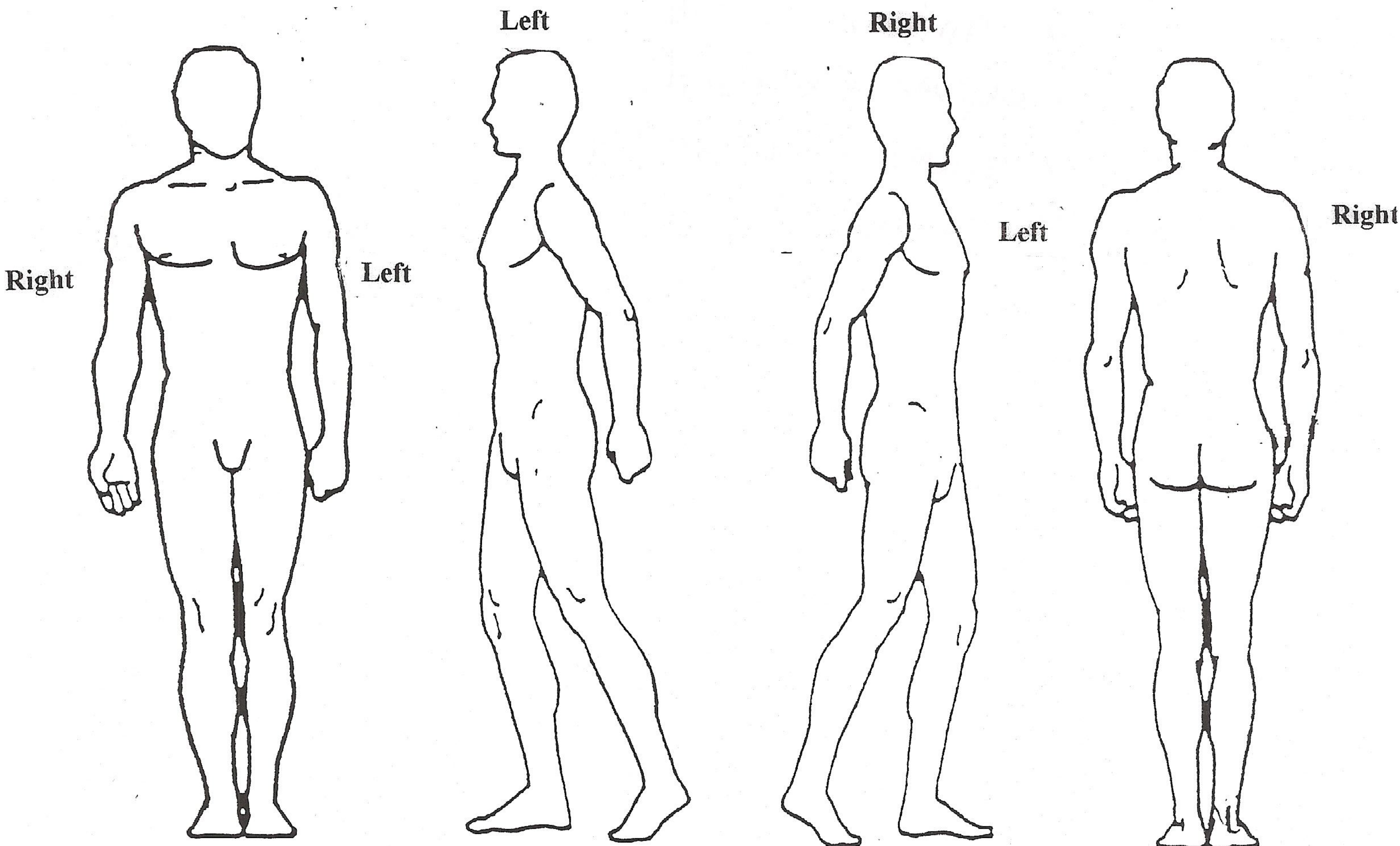
PLEASE SHADE IN THE AREAS YOU HAVE DISCOMFORT




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: __________