

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

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

Neck

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

Upper Back

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

Lower Back

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

Headache

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

Shoulder

<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10</u>
No pain									Unbearable Pain	

Arm

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

Hip

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

Other

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