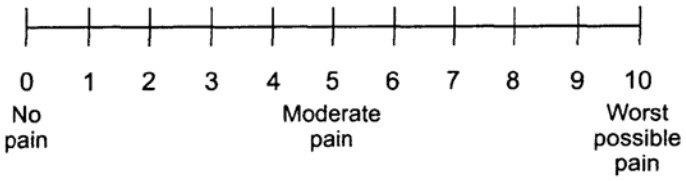
Patient Name: _____ Date: _____

0-10 Numeric Pain Intensity Scale*



Please provide two pain rating numbers:

-Pain rating today. _____
-Pain rating at worst since this condition started. _____

In the space below, please describe both the location(s) and type of pain (aching, sharp, dull, burning, etc.) that you are experiencing currently.

Location(s): _____

Type of Pain: _____