

# PAIN RATING SCALE

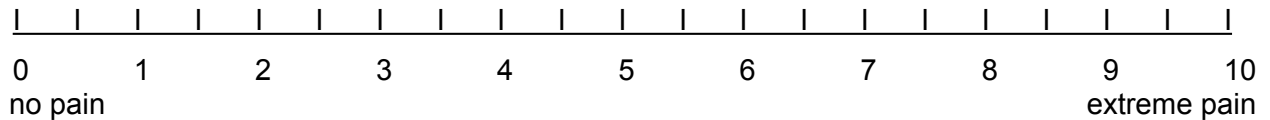
(English)

Title: ..... Date:.....  
First Name:..... Patient number:.....  
Surname:..... Clinic: .....

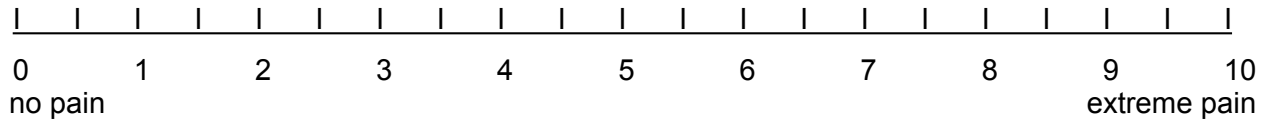
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Please mark the scale below to show how intense your pain is.  
A zero (0) means no pain, and ten (10) means extreme pain.

How **intense** is your pain **now**?



How **intense** was your pain **on average last week**?



Now please use the same method to describe how **distressing** your pain is.

How **distressing** is your pain **now**?



How **distressing** was your pain **on average last week**?



Now please use the same method to describe **how much your pain interferes** with your normal everyday activities.



If you have had treatment for your pain, how much has this relieved (taken away) the pain?

