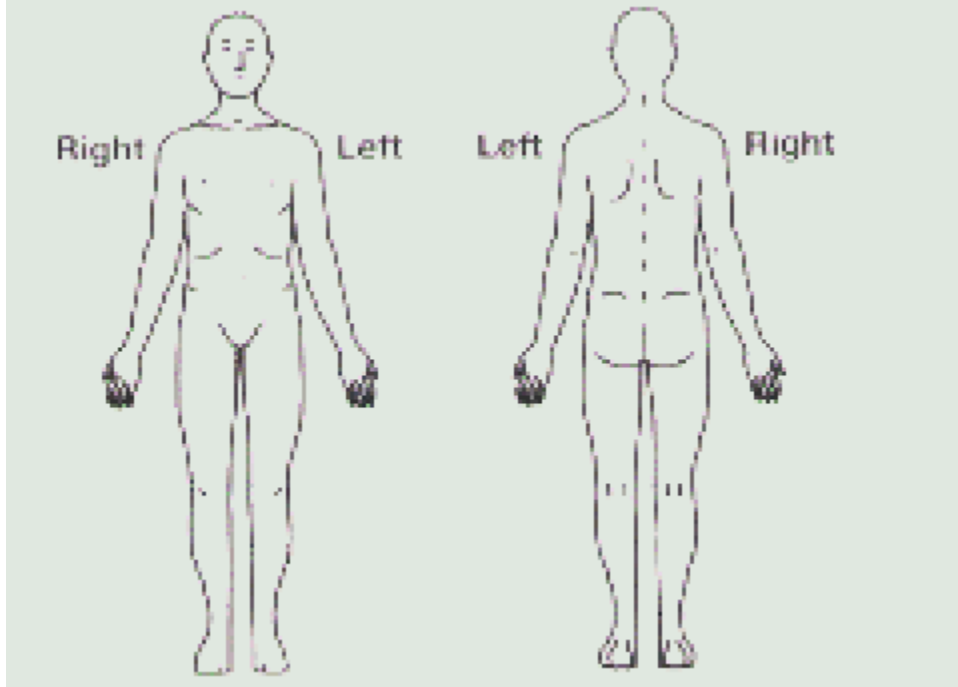


Pain Inventory

Name: _____ Date of birth: _____ Today's date: ___/___/___

Most of us have pain from time to time (such as minor headaches, sprains, and toothaches). Do you have pain different from these everyday kinds of pain **today**? ___yes ___no

On the diagram, **shade in** the areas where you feel pain. **Put an X** on the ONE area that hurts the most.



Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No pain at all Pain bad enough you are hospitalized with IV pain drugs

Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No pain at all Pain bad enough you are hospitalized with IV pain drugs

Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0 1 2 3 4 5 6 7 8 9 10
No pain at all Pain bad enough you are hospitalized with IV pain drugs

Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0 1 2 3 4 5 6 7 8 9 10
No pain at all Pain bad enough you are hospitalized with IV pain drugs

