Pain Scale

Name_____ Date:_____

Please mark a vertical line on the scales below representing how severe your pain is.

(For example) (Absent) _____ (Severe)

Rate the pain you have right now:

(Absent) _____ (Severe)

Rate your pain at its best in the past week:

(Absent) _____ (Severe)

Rate your pain at its worst in the past week:

(Absent) _____ (Severe)

Rate your average pain in the last week:

(Absent) _____ (Severe)

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