

Numeric Pain Rating Scale

Date: _____

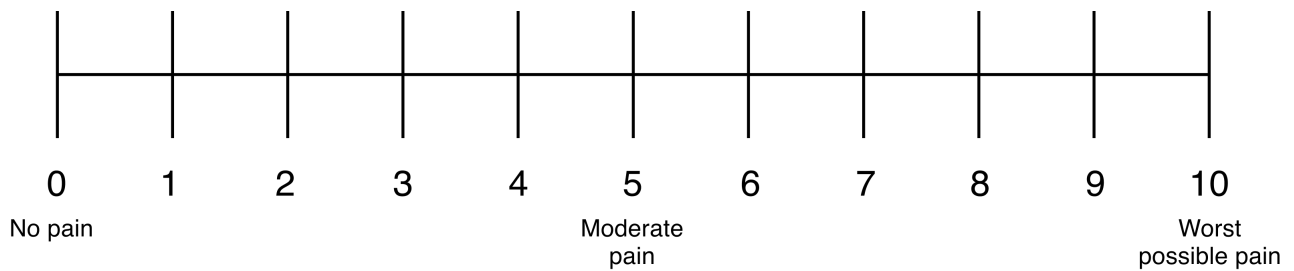
Patient's name: _____ Age: _____ Gender: _____

Date of birth: _____ Contact information: _____

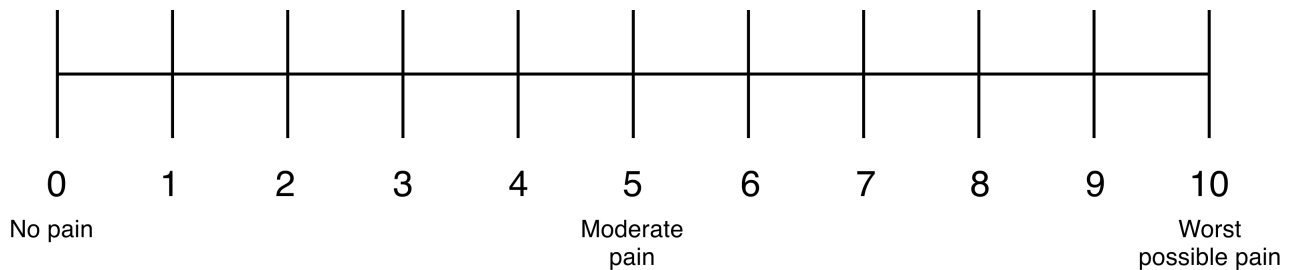
Other relevant medical information (if needed):

Instructions

Rate yourself from 0 to 10, with 0 meaning you feel/felt no pain at all and 10 meaning you feel/felt the worst pain imaginable.

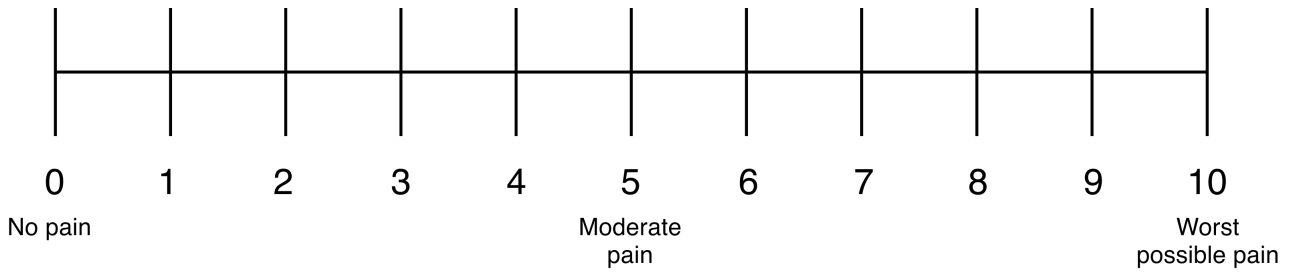


Time: _____



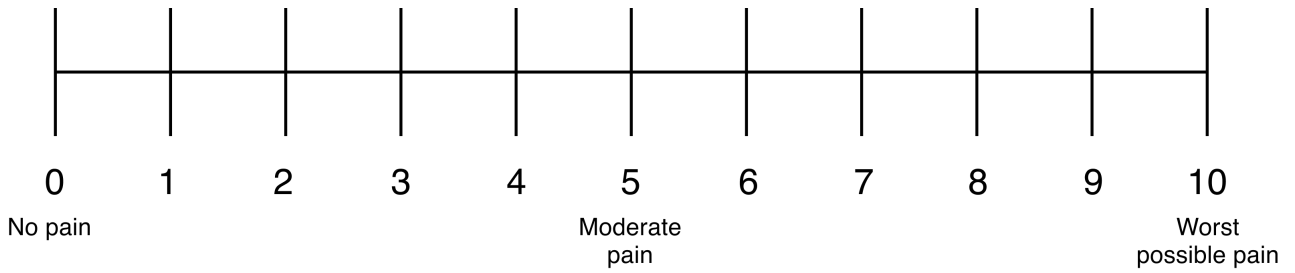
Notes:

Time: _____



Notes:

Time: _____



Notes:

Average score: _____

Additional notes