

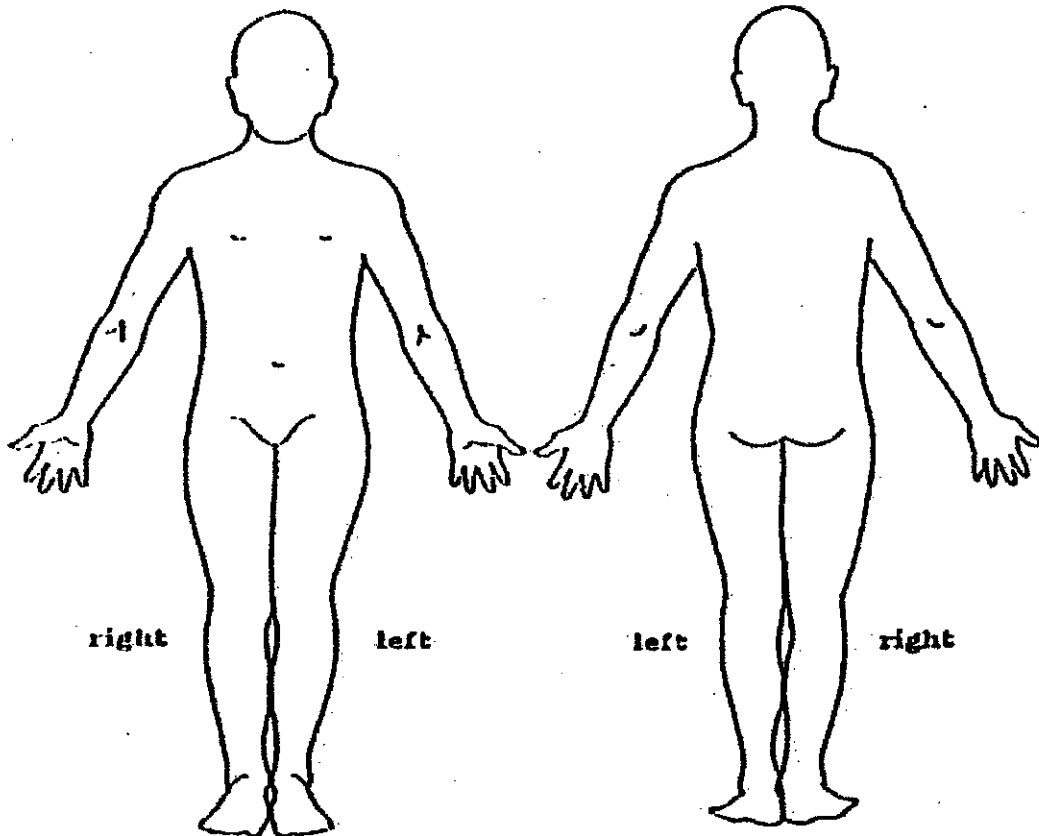
# PATIENT PAIN SCALE

PATIENT NAME: \_\_\_\_\_

ACCT #: \_\_\_\_\_

DATE: \_\_\_\_\_

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain from 1 (being the least pain) to 10 (being the most severe pain) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	10
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PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_