

Pain Rating Scale

- Low Back
- Neck
- Other: _____

Print Name: _____

Date: _____

Signature: _____

Instructions: Please choose the number which best describes your pain in each of the questions below:

1. What is your pain RIGHT NOW?

0	0	0	0	0	0	0	0	0	0	0
0	1	2	3	4	5	6	7	8	9	10

No Pain

Unbearable Pain

2. What is your TYPICAL or AVERAGE pain?

0	0	0	0	0	0	0	0	0	0	0
0	1	2	3	4	5	6	7	8	9	10

No Pain

Unbearable Pain

3. What is your pain AT ITS WORST?

0	0	0	0	0	0	0	0	0	0	0
0	1	2	3	4	5	6	7	8	9	10

No Pain

Unbearable Pain

4. What is your pain AT ITS BEST?

0	0	0	0	0	0	0	0	0	0	0
0	1	2	3	4	5	6	7	8	9	10

No Pain

Unbearable Pain

Quality of your pain (circle all that apply):

- Stiff / Pinching / Deep / Superficial / Soreness
- Dull / Sharp / Burning / Achy / Shooting
- Sharp with Movement / Dull and Achy, but Sharp with Movement
- Stabbing / Throbbing