

PAIN RATING SCALE

Name: _____

Date: _____

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

1. What was your pain BEFORE your most recent accident? (0 = No Pain 10 = Unbearable Pain)

Head	0	1	2	3	4	5	6	7	8	9	10
Neck	0	1	2	3	4	5	6	7	8	9	10
Upper Back	0	1	2	3	4	5	6	7	8	9	10
Low Back	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

2. What is your pain RIGHT NOW? (0 = No Pain 10 = Unbearable Pain)

Head	0	1	2	3	4	5	6	7	8	9	10
Neck	0	1	2	3	4	5	6	7	8	9	10
Upper Back	0	1	2	3	4	5	6	7	8	9	10
Low Back	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

3. What is your TYPICAL or AVERAGE pain? (0 = No Pain 10 = Unbearable Pain)

Head	0	1	2	3	4	5	6	7	8	9	10
Neck	0	1	2	3	4	5	6	7	8	9	10
Upper Back	0	1	2	3	4	5	6	7	8	9	10
Low Back	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

4. What is your pain AT ITS WORST? (0 = No Pain 10 = Unbearable Pain)

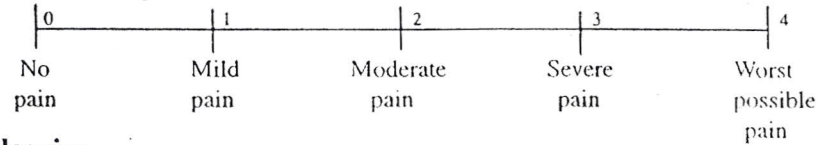
Head	0	1	2	3	4	5	6	7	8	9	10
Neck	0	1	2	3	4	5	6	7	8	9	10
Upper Back	0	1	2	3	4	5	6	7	8	9	10
Low Back	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

Functional Rating Index

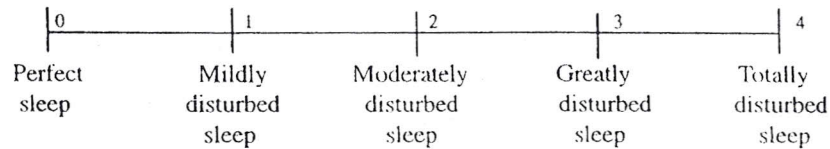
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

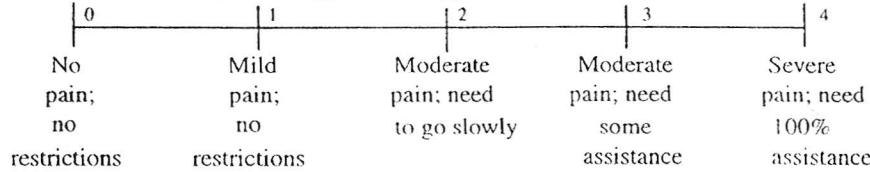
1. Pain Intensity



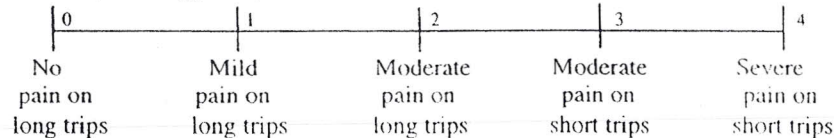
2. Sleeping



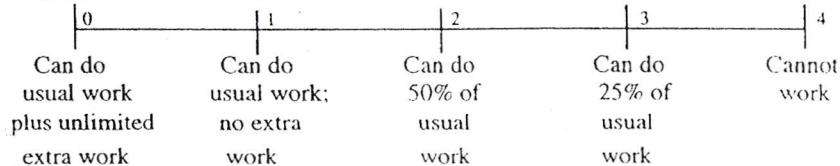
3. Personal Care (washing, dressing, etc.)



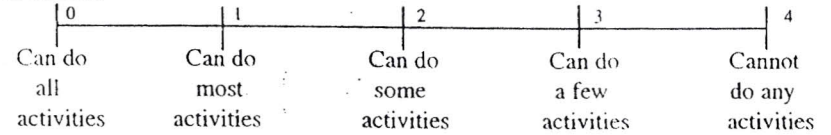
4. Travel (driving, etc.)



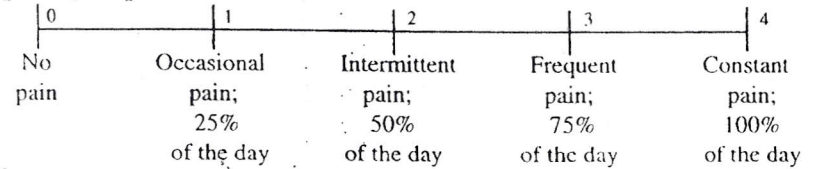
5. Work



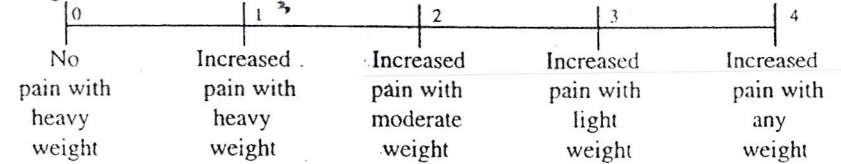
6. Recreation



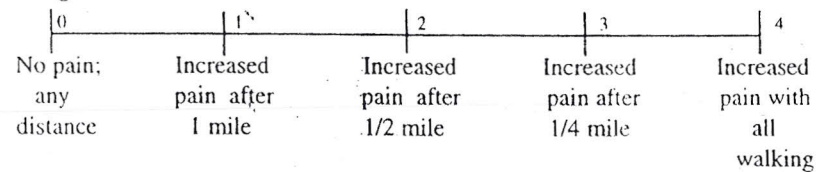
7. Frequency of pain



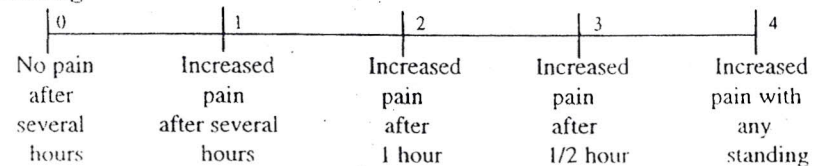
8. Lifting



9. Walking



10. Standing



Name _____ ID# _____ Plan ID _____ Total Score _____

PRINTED

Revised 10/07

Signature _____

Date _____

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