

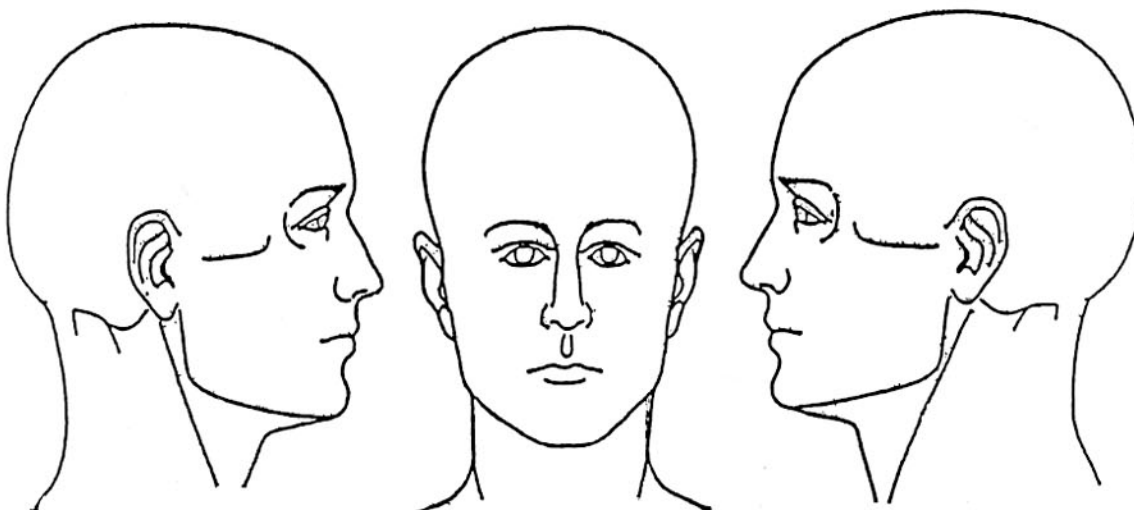
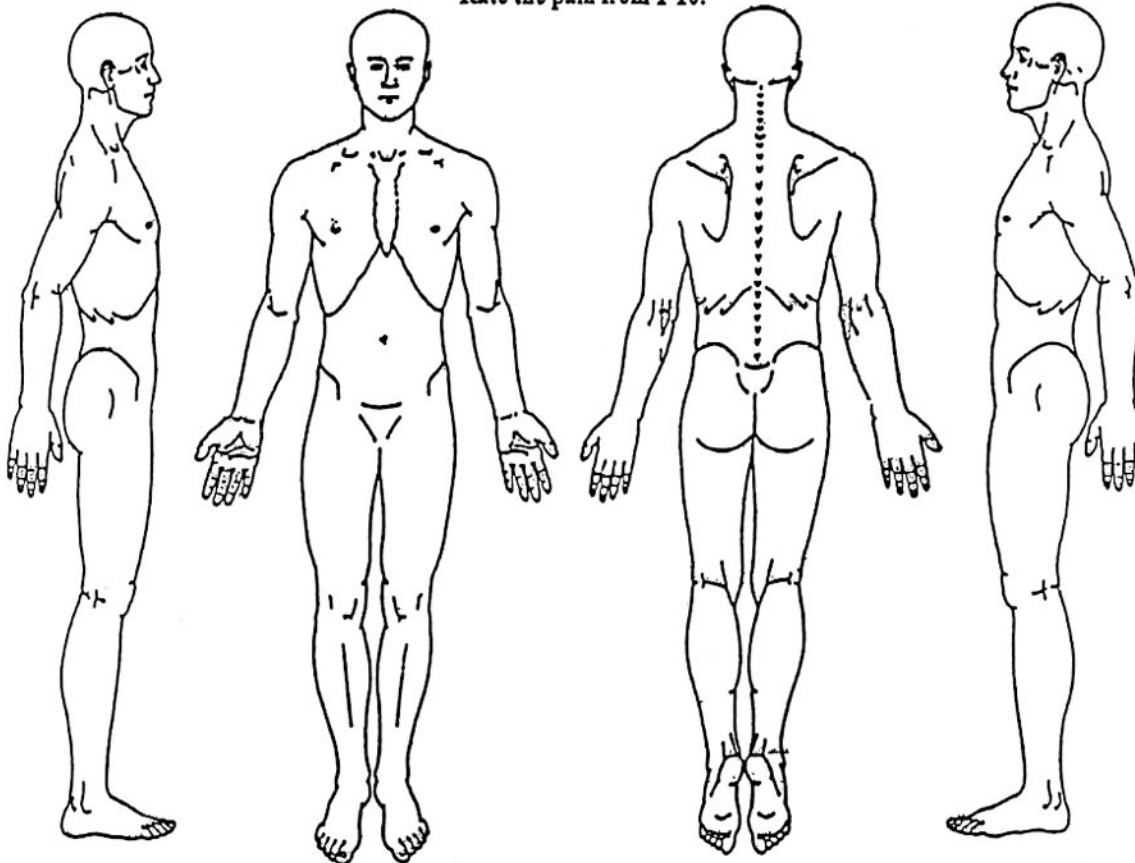
Please mark using the following symbols:

A: Achy C: Constant R: Radiating  
 S: Sharp D: Dull Sm: Spasm  
 T: Tightness N: Numb

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Rate the pain from 1-10.



**Pain Scale (0 - 10)**

0-1	= Minimal	= The pain is an annoyance but does not stop me from working.
2-3	= Slight	= I can tolerate the pain but it causes some difficulty in doing my work. However, it does not stop me from working.
5	= Moderate	= The pain causes a marked handicap in my ability to work but I can continue.
7-8	= Moderate To Severe	= The pain is approaching the worst I have ever experienced or could imagine. It causes a significant problem with working and most of the time I can't.
10	= Severe	= The pain is the worst I have ever experienced or could imagine and causes me to stop all work and activity.