



Patient's Name: \_\_\_\_\_

# Show me where it hurts

0

no pain

1

mild pain that I am sometimes aware of but not bothered by

2

moderate pain that I can tolerate without medication

3

moderate pain that is intolerable without medication

4

severe pain

5

6

more severe pain

7

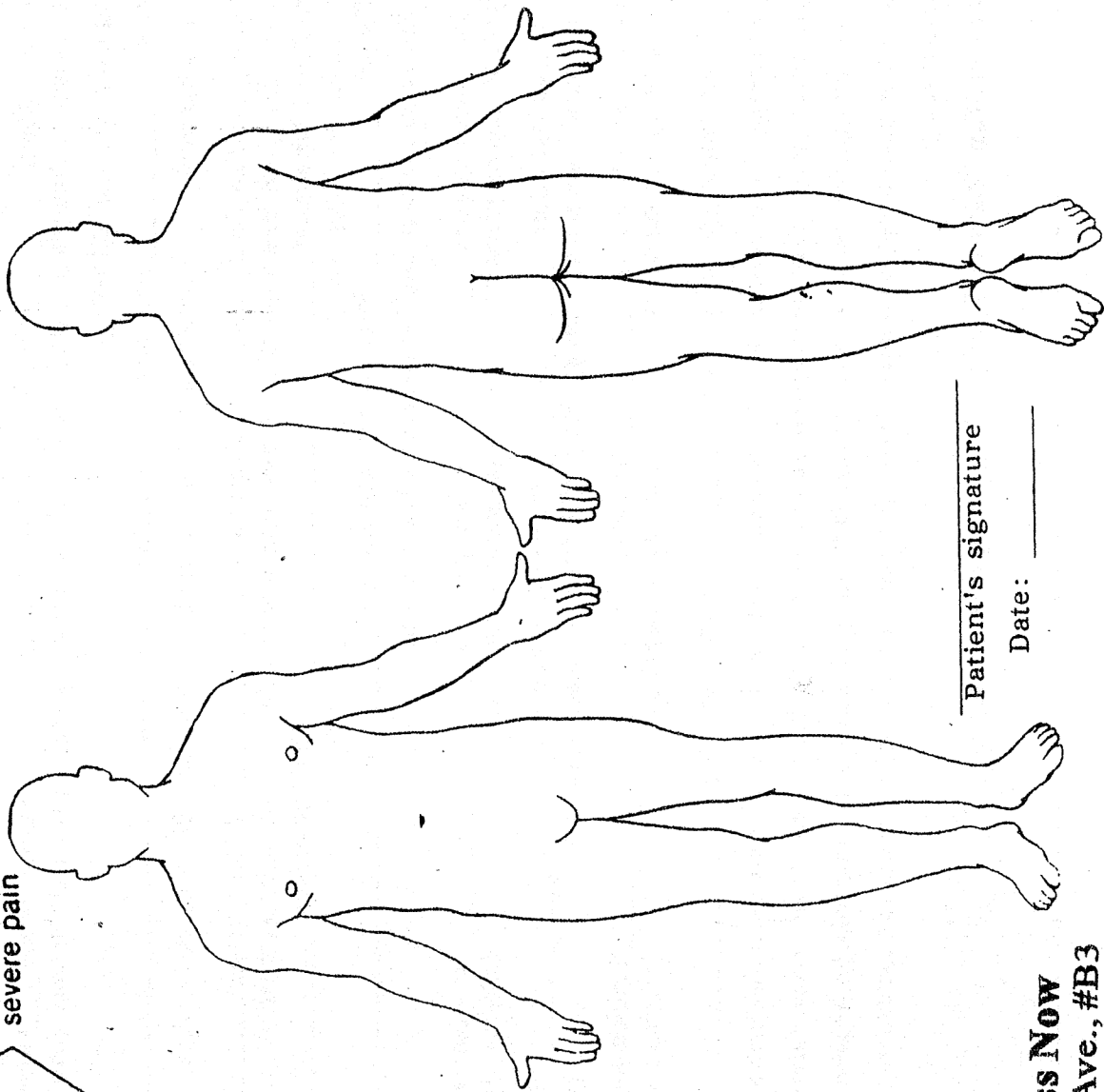
8

intensely severe pain

9

10

most severe pain



\_\_\_\_\_  
Patient's signature

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