

Week Number:

To be filled out once during each 2 weeks of treatment

What is your pain RIGHT NOW? Part of Body:										
0	1	2	3	4	5	6	7	8	9	10
No pain	Minimal pain; No loss of function			Slight pain; Some altered function		Moderate pain; Function altered greatly		Severe pain; no function		Needs emergency care
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What is your TYPICAL or AVERAGE pain?										
0	1	2	3	4	5	6	7	8	9	10
No pain	Minimal pain; No loss of function			Slight pain; Some altered function		Moderate pain; Function altered greatly		Severe pain; no function		Needs emergency care
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What is your pain at its BEST (how close to “no pain” does your pain get at its best)?										
0	1	2	3	4	5	6	7	8	9	10
No pain	Minimal pain; No loss of function			Slight pain; Some altered function		Moderate pain; Function altered greatly		Severe pain; no function		Needs emergency care
What relieves your pain? <hr/> <hr/>										

What is your pain at its WORST (how close to “needs emergency care” does your pain get at its worst)?										
0	1	2	3	4	5	6	7	8	9	10
No pain	Minimal pain; No loss of function			Slight pain; Some altered function		Moderate pain; Function altered greatly		Severe pain; no function		Needs emergency care
What makes your pain worse? <hr/> <hr/>										

What percentage of the time do you experience your pain each day? 25% 50% 75% 100%

How many days a week do you have pain? 1 2 3 4 5 6 7

Since your injury started, what percentage has your pain decreased overall?

NAME: _____ DATE: _____