Numeric Pain Rating Scale

NUMERIC PAIN RATING SCALE

Date: _____ dd / mm / yyyy

Patient's name: _____

Age: _____

Gender: _____

Date of birth: _____ dd / mm / yyyy

Contact information: _____

Other relevant medical information (if needed):

INSTRUCTIONS

Rate yourself from 0 to 10, with 0 meaning you feel/felt no pain at all and 10 meaning you feel/felt the worst pain imaginable.

RATING SCALE

1. Date/time: _____

Select one:

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

Notes:

2. Date/time: _____

Select one:

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

Notes:

3. Date/time: _____

Select one:

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

Notes:

Average score: _____

ADDITIONAL NOTES

Specify below: