

# Pain Rating Scale

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

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

1. What is your pain RIGHT NOW?

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

No Pain

Unbearable Pain

2. What is your TYPICAL or AVERAGE pain?

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

No Pain

Unbearable Pain

3. What is your pain AT ITS WORST?

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

No Pain

Unbearable Pain