

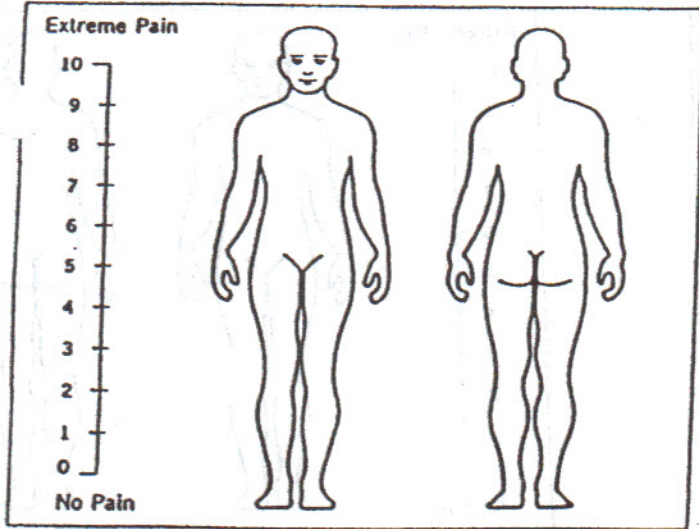
PAIN ASSESSMENT

Name _____ Date _____

Extreme Pain

10
9
8
7
6
5
4
3
2
1
0

No Pain



Please indicate the areas of your pain on the figures above. Then mark the severity of your pain on the scale of 0-10.

Describe any changes in your condition or any new concerns:

Patient Signature _____

#20440 - Medical Arts Press 1-800-326-2179

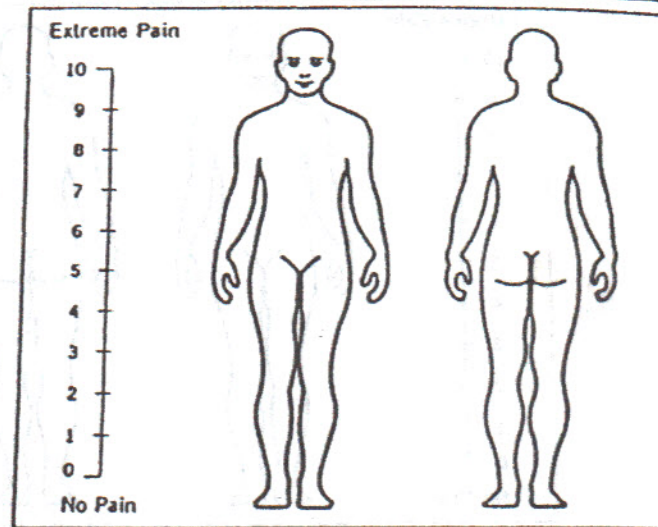
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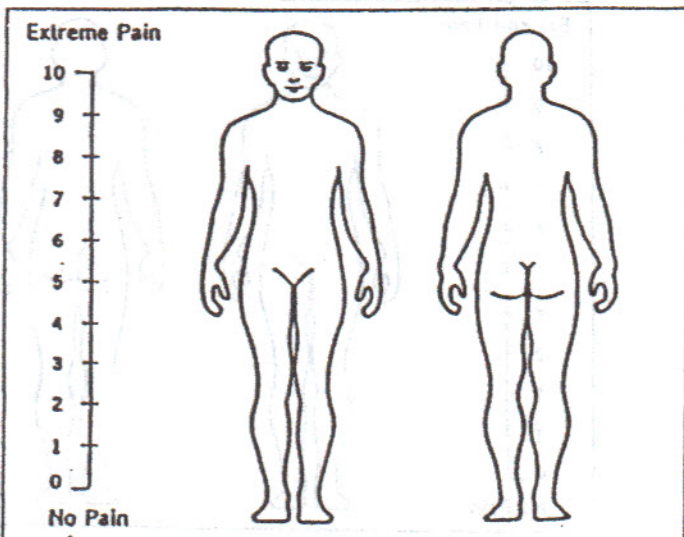
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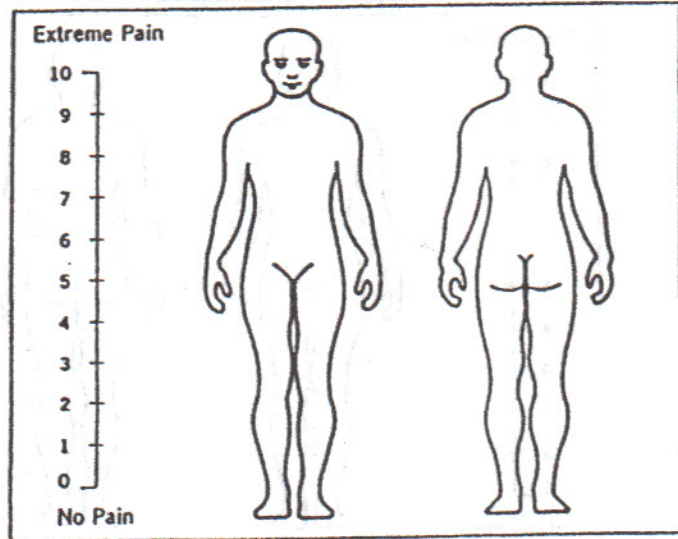
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