Everyday Brain Fitness & Bioflex Laser

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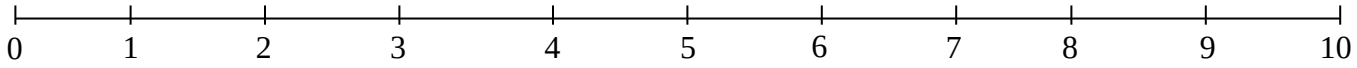
Client Pain Assessment

Name: _____ _____ _____
Last **First** **Date**

0-10 Numeric Pain Intensity Scale (1)



No Pain **Mild Pain** **Moderate Pain** **Severe Pain** **Very Severe** **Intolerable Pain**

1) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.
0 1 2 3 4 5 6 7 8 9 10
No Pain Intolerable Pain

2) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.
0 1 2 3 4 5 6 7 8 9 10
No Pain Intolerable Pain

3) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.
0 1 2 3 4 5 6 7 8 9 10
No Pain Intolerable Pain

4) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.
0 1 2 3 4 5 6 7 8 9 10
No Pain Intolerable Pain

5) What treatments or medications are you receiving for your pain? _____

6) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity
0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

B. Walking ability
0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

C. Normal work (includes both work outside the home and housework)
0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

D. Sleep
0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

E. Enjoyment of life
0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes