

Quadruple Numerical Rating Scale

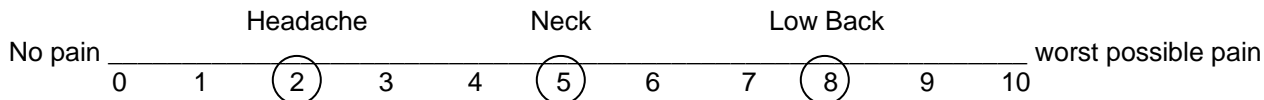
FAX (800) 599-8350

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY) ____/____/____
Provider Last Name	Provider First Name	Provider Phone (area code first)	

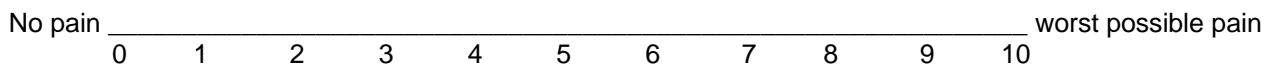
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

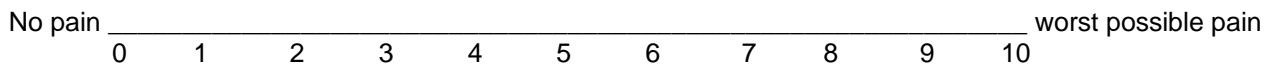
Example:



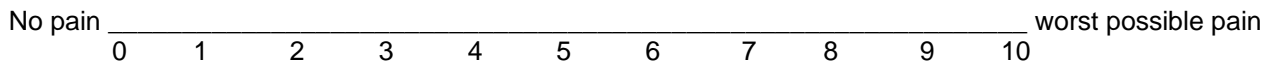
1. What is your pain **RIGHT NOW**?



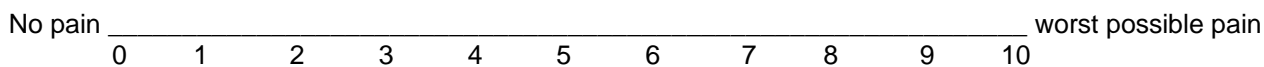
2. What is your **TYPICAL** or **AVERAGE** pain?



3. What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best)?



4. What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature _____ Date _____

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