P4 PAIN INTENSITY MEASURE

Patient Name: _____ Date of Birth:_____

_____ Date:_____

When answering these questions, think only of the pain you are experiencing in relation to the problem for which you are having treatment. Circle 1 number for each of the 4 questions.

On average, how bad has your pain been?

	NO PAIN									PAIN AS BAD AS IT CAN BE
In the morning over the past 2 days	0	1	2	3	4	5	6	7	8	9	10
In the afternoon over the past 2 days	0	1	2	3	4	5	6	7	8	9	10
In the evening over the past 2 days	0	1	2	3	4	5	6	7	8	9	10
With activity over the past 2 days	0	1	2	3	4	5	6	7	8	9	10

Office Use Only
Score: _____ **/40**