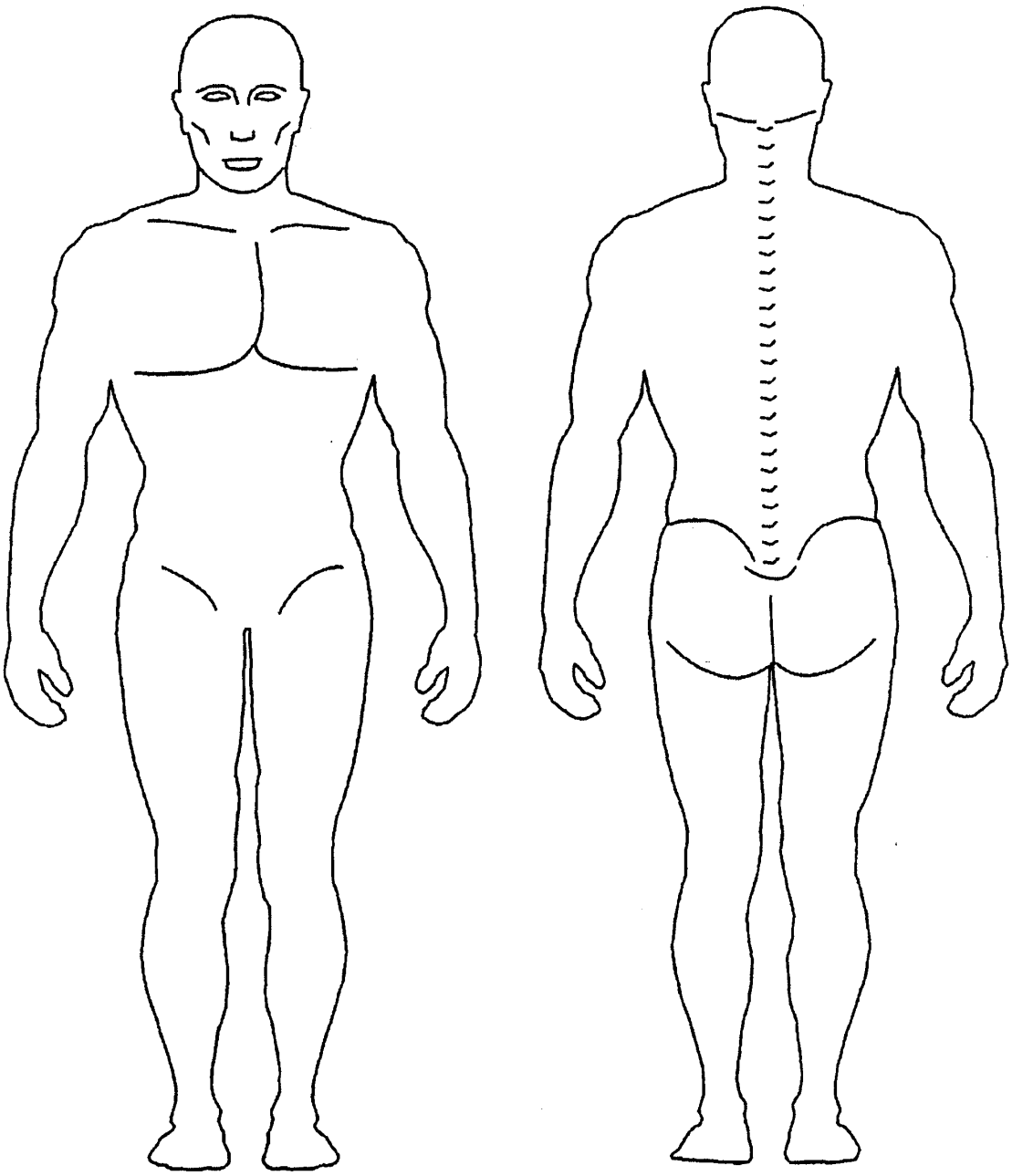
PAIN QUESTIONNAIRE IMAGE

Name:

Date:
Patient's Age:

Rate Your Pain:

0 1 2 3 4 5 6 7 8 9 10

no pain **worst possible pain**