







PATIENT NAME: _____

Circle one:

0	2	4	6	8	10
					
NO HURT	HURTS A LITTLE BIT	HURTS A LITTLE MORE	HURTS EVEN MORE	HURTS A WHOLE LOT	HURTS WORST

Wong-Baker FACES Pain Rating Scale

1. Location of Pain: _____

2. Duration of Pain: Hours Days Weeks Months

3. Describe the pain: Sharp Dull Aching

4. Was this the result of an injury? Yes No

5. Was the injury work related? Yes No

6. What actions or movements cause aggravation to the area?

7. Relieving Factors are: Ice Heat Rest Medication

8. Wants Injections? Yes No

9. Medication Refill? Yes No

10. New Patients only, who were you referred by?

- Dr. _____
- Family/Friend: _____
- Patient: _____

Additional Questions?
