

Name and surname:

Date of Birth:

Date of completing this questionnaire:

Pain Scale for the Last Month

Please characterize the strength of your pain on a scale from 0 to 10 in the last one month (last 30 days). Where 0 = no pain at all, and 10 = pain as bad as it could be. Please circle the correct number.

0 1 2 3 4 5 6 7 8 9 10
