Applied Psychological Health
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PAIN INVENTORY

Date: _____

Name: _____

Pain Location: _____

1. Please rate your pain by circling the one number that best describes your pain at its **worst** during the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Ever/ Unbearable

2. Please rate your pain by circling the one number that best describes your pain at its **least** during the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Ever/ Unbearable

3. Please rate your pain by circling the one number that best describes your pain **on average**.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Ever/ Unbearable

4. Please rate your pain by circling the one number that best describes your pain **right now**.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Ever/ Unbearable

What kinds of things make your pain feel better (for example: heat, medication, rest, etc.):

_____

_____

_____

What kinds of things make your pain feel worse (for example: walking, certain movements, etc.):

_____

_____

_____

Of the twelve-hour period ranging from 9:00 AM to 9:00 PM on an average day, about how many hours would you estimate that you spend either sitting or lying down due to pain? _____