

Pain Intensity – Short Form 3a

Please respond to each item by marking one box per row.

In the past 7 days...		Had no pain	Mild	Moderate	Severe	Very severe
PAINQU6	How intense was your pain at its worst?....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
PAINQU8	How intense was your average pain?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
		No pain	Mild	Moderate	Severe	Very severe
PAINQU21	What is your level of pain right now?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

SAMPLE