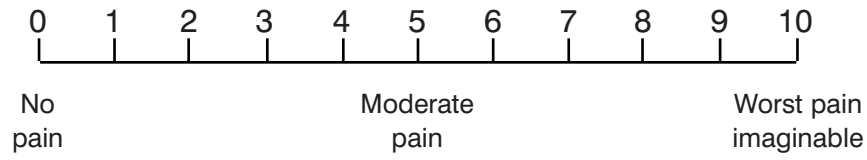


Patient Name: _____ Date: _____

0-10 Numeric Pain Intensity Scale



0-10 Numeric Pain Distress Scale

