

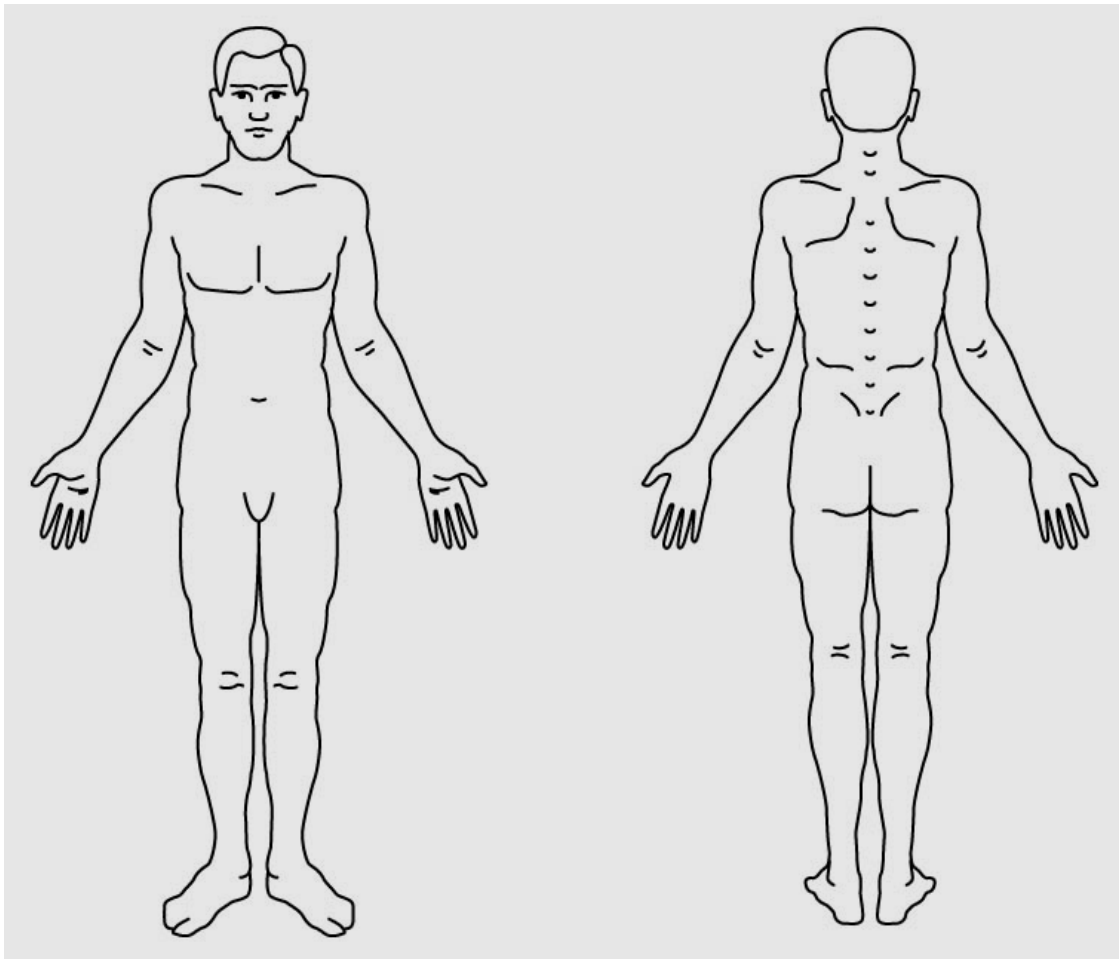
**Advanced**  
**Neurosurgery**  
**PAIN INVENTORY**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_

\_\_\_\_\_ Last First Middle Initial

- 1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?  
Yes No
- 2) On the diagram below, shade in the areas where you feel pain. Put an X on the area that hurts the most.



- 3) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10  
No pain Pain as bad as you can imagine



