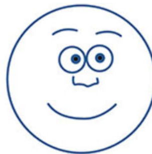
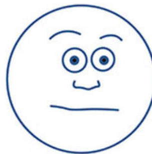
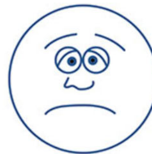
Date: __________

Patient First Name: ___________________________ Last Name: _______________________________________

Please color how you are feeling and what you would like help with:

Wong-Baker FACES® Pain Rating Scale

					
0	**2**	**4**	**6**	**8**	**10**
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst