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PATIENT NAME:_____ DATE: _____DOB:_____

Please **list 3-5 important activities** that you are unable to do or are having difficulty doing as a result of your pain, injury or surgery. Then **rate the level of difficulty** you are having with the 3-5 activities you listed using the 0-10 scale:

0 is unable to perform the activity; 10 is no difficulty with the activity.

ACTIVITY	PATIENT SPECIFIC ACTIVITY SCORING SCALE
Example only: Walking up stairs	
1.	**Unable** … **No difficulty** 0 1 2 3 4 5 6 7 8 9 10
2.	**Unable** … **No difficulty** 0 1 2 3 4 5 6 7 8 9 10
3.	**Unable** … **No difficulty** 0 1 2 3 4 5 6 7 8 9 10
4.	**Unable** … **No difficulty** 0 1 2 3 4 5 6 7 8 9 10
5.	**Unable** … **No difficulty** 0 1 2 3 4 5 6 7 8 9 10

Please rate your pain on the following scale⟹	0-10 NUMERIC PAIN RATING SCALE
Current	**No pain** … **Moderate pain** … **Worst pain** 0 1 2 3 4 5 6 7 8 9 10
Best	**No pain** … **Moderate pain** … **Worst pain** 0 1 2 3 4 5 6 7 8 9 10
Worst	**No pain** … **Moderate pain** … **Worst pain** 0 1 2 3 4 5 6 7 8 9 10