NUMERIC RATING SCALE

Name:_____ **Date:**_____/_____/___**Claim #:**_____

SYMPTOMS (only check if applicable)		**MILD<<< >>>SEVERE**
✓	EXAMPLE	1 2 3 4 5 6 7 8 9 10
	Neck Pain	1 2 3 4 5 6 7 8 9 10
	Neck Stiffness	1 2 3 4 5 6 7 8 9 10
	Headaches	1 2 3 4 5 6 7 8 9 10
	Dizziness / Vertigo	1 2 3 4 5 6 7 8 9 10
	Jaw Pain	1 2 3 4 5 6 7 8 9 10
	Upper Back Pain	1 2 3 4 5 6 7 8 9 10
	Left Shoulder Pain	1 2 3 4 5 6 7 8 9 10
	Right Shoulder Pain	1 2 3 4 5 6 7 8 9 10
	Left Arm/Hand Pain/Numb (circle)	1 2 3 4 5 6 7 8 9 10
	Right Arm/Hand Pain/Numb (circle)	1 2 3 4 5 6 7 8 9 10
	Middle Back Pain	1 2 3 4 5 6 7 8 9 10
	Low Back Pain	1 2 3 4 5 6 7 8 9 10

	Left Hip/SI Pain/Numb (circle)	1 2 3 4 5 6 7 8 9 10
	Right Hip/SI Pain/Numb (circle)	1 2 3 4 5 6 7 8 9 10
	Knee Pain Left / Right (circle)	1 2 3 4 5 6 7 8 9 10
	Left Leg/Foot Pain/Numb (circle)	1 2 3 4 5 6 7 8 9 10
	Right Leg/Foot Pain/Numb (circle)	1 2 3 4 5 6 7 8 9 10
	Ear Buzzing/Ringing	1 2 3 4 5 6 7 8 9 10
	Fatigue	1 2 3 4 5 6 7 8 9 10
	Irritability	1 2 3 4 5 6 7 8 9 10
	Short of Breath	1 2 3 4 5 6 7 8 9 10
	Sleep Difficulty	1 2 3 4 5 6 7 8 9 10
	Nausea / Stomach Upset	1 2 3 4 5 6 7 8 9 10
	Tension	1 2 3 4 5 6 7 8 9 10
	Blurred Vision	1 2 3 4 5 6 7 8 9 10
	Memory Loss	1 2 3 4 5 6 7 8 9 10
	Other:	1 2 3 4 5 6 7 8 9 10
	Other:	1 2 3 4 5 6 7 8 9 10

	Other:	1 2 3 4 5 6 7 8 9 10