## **Assessment:**

## **Faces Pain Rating Scale**

Name			Room		
Time	Date		_		
Assessed By	<i>y</i>				-
Directions Ask person		ne face that best reflec	ets how he/she fe	els.	
1. No Pain	2. Mild Pai	3. n Discomforting	4. Distressing	5. Intense	6. Excruciating
Date	Time		Comm	nents	

Date	Time	Comments		
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