ROCKFORD NEUROSCIENCE CENTER
CHILDREN'S PAIN SCALE

Patient Name: _____ **Physician Name:** _____ **Date Started:** _____

Circle the face that best shows your headache pain for the day. ☺ **= Mild Pain** 😐 **= Moderate Pain** ☹ **= Severe Pain**
If no pain that day, leave space blank.

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹
_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹
_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹
_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹
_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹	_____ DATE ☺ 😐 ☹