Brief Extremity Rating Index

For use with **Extremity Problems**.

Patient Name	Date	Date	
Location of Condition			

Please circle the number which most closely describes your condition right now.

1. Pain Intensity



2. Frequency of pain

0	1	2	3	4
	I			
No	Occasional	Intermittent	Frequent	Constant
pain	pain;	pain;	pain;	pain;
	25%	50%	75%	100%
	of the day	of the day	of the day	of the day

3. Function

