Name:

Edmonton Symptom Assessment Scale
Numerical Scale

Please circle the number that best describes:

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst possible pain
Not tired	0	1	2	3	4	5	6	7	8	9	10	Worst possible tiredness
Not nauseated	0	1	2	3	4	5	6	7	8	9	10	Worst possible nausea
Not depressed	0	1	2	3	4	5	6	7	8	9	10	Worst possible depression
Not anxious	0	1	2	3	4	5	6	7	8	9	10	Worst possible anxiety
Not drowsy	0	1	2	3	4	5	6	7	8	9	10	Worst possible drowsiness
Best appetite	0	1	2	3	4	5	6	7	8	9	10	Worst possible appetite
Best feeling of wellbeing	0	1	2	3	4	5	6	7	8	9	10	Worst possible feeling of wellbeing
No shortness of breath	0	1	2	3	4	5	6	7	8	9	10	Worst possible shortness of breath
Best bowel function	0	1	2	3	4	5	6	7	8	9	10	Worst possible bowel function
Other problem	0	1	2	3	4	5	6	7	8	9	10	

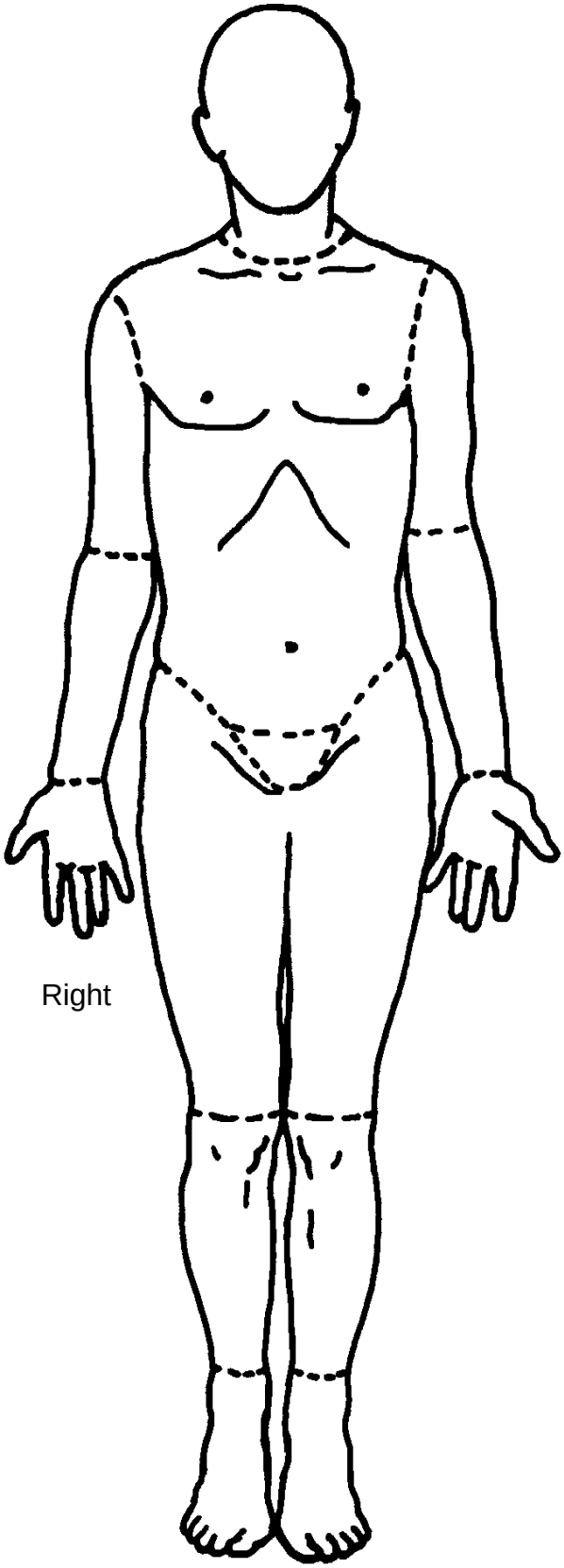
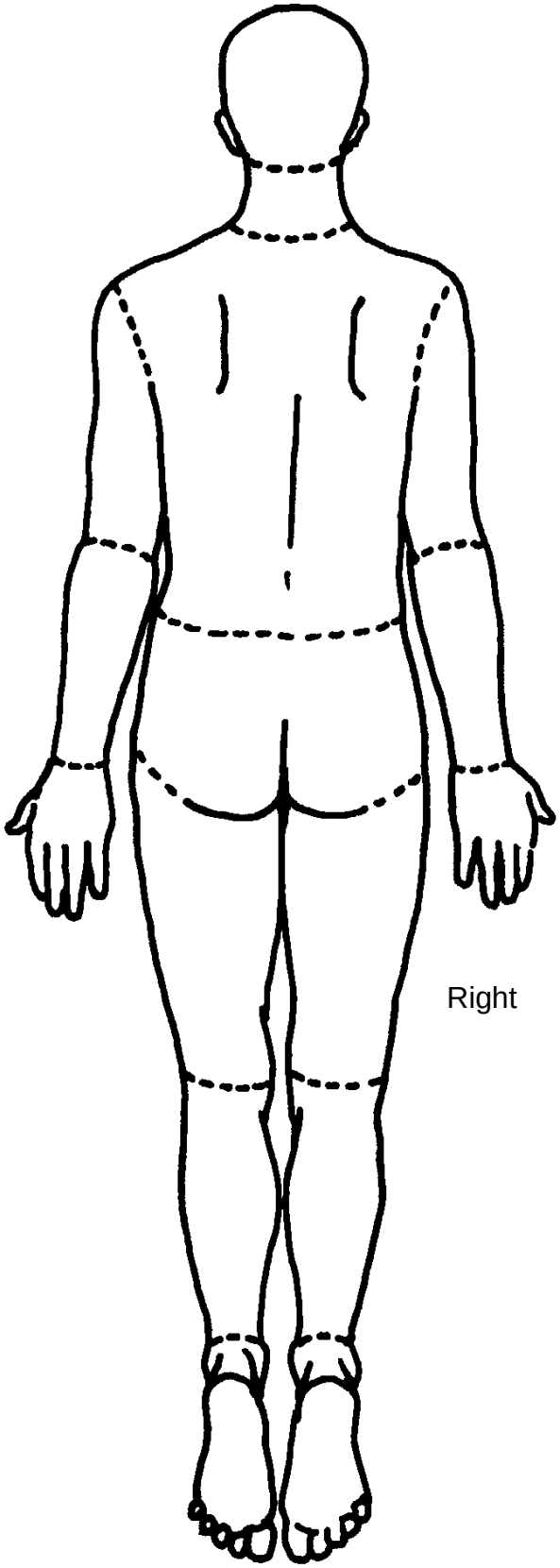
Person's Name _____

Date_____ Time _____

Complete by (check one)

- ☐ Person
- ☐ Caregiver
- ☐ Caregiver - assisted

BODY DIAGRAM ON REVERSE SIDE

Used with permission, Regional Palliative Care Program, Capital Health, Edmonton, AB, 2003

Please mark on these pictures where it is you hurt.