

INITIAL PAIN ASSESSMENT

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Patient Name _____ Date _____
Date of Birth _____ Sex _____ Marital Status _____
Telephone Numbers/Home () _____ Work () _____
Home Address _____
Street _____
City _____ State _____ ZIP _____

By answering the following questions, you will help your physician better understand and treat your pain.

When and how did your pain problem start? _____

As far as you know, what is the cause of your pain (ie, the diagnosis)? _____

What doctors have you seen? When did you see them? What did they do? (for example: Doctor did physical exam, ordered tests, prescribed medication)

Doctor's Name	Month/Year Seen	What Was Done
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What tests and studies have been done? (for example: MRI, CT-Scan, X-Rays)	Month/Year Done	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List the body sites where you experience pain and circle the words that best describe the pain at that site. Also, indicate the intensity of the pain and those things that make your pain better or worse. Use a separate sheet for each body site.

Body Site _____

Circle the words that describe your pain.

- | | | |
|--------------|------------|-------------|
| Aching | Sharp | Penetrating |
| Throbbing | Tender | Nagging |
| Shooting | Burning | Numb |
| Stabbing | Exhausting | Miserable |
| Gnawing | Tiring | Unbearable |
| Intermittent | Continuous | |

Circle the number that best describes your pain at its **worst during the last month**.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

Circle the number that best describes your pain at its **least during the last month**.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

Circle the number that best describes your pain **on average during the last month**.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

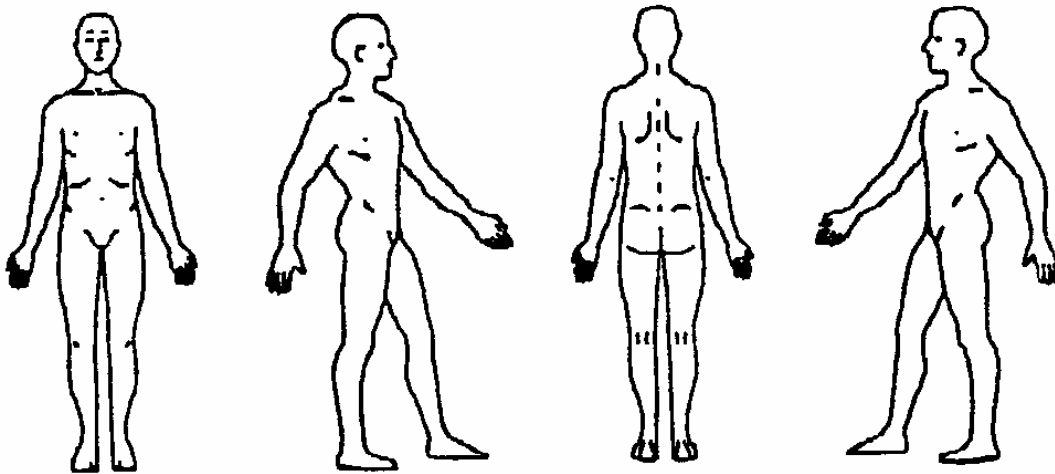
Circle the number that best describes your pain as it is **right now**.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

What sorts of things make this pain feel **better** (for example: heat, rest, medicine)?

What sorts of things make this pain feel **worse** (for example: walking, standing, lifting)?

On the diagram below, shade the area(s) where you feel pain. "X" the areas that hurt the most.



What pain treatments or medications are you receiving now or have received in the past? (For example, pain medications, physical therapy, acupuncture, TENS, etc.) Circle the number next to the treatment to signify the amount of pain relief that treatment is providing or has provided.

Treatment or Medication	No Relief	Complete Relief	Check If Receiving Now
	0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/>
	0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/>
	0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/>
	0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/>
	0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/>
	0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/>
	0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/>

Circle the numbers below that best describe how pain has interfered with your daily functioning.

General Activity

0	1	2	3	4	5	6	7	8	9	10
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Does not interfere Completely interferes

Mood

0	1	2	3	4	5	6	7	8	9	10
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Does not interfere Completely interferes

Walking Ability

0	1	2	3	4	5	6	7	8	9	10
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Does not interfere Completely interferes

Normal Work Routine

0	1	2	3	4	5	6	7	8	9	10
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Does not interfere Completely interferes

Relations With Other People

0	1	2	3	4	5	6	7	8	9	10
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Does not interfere Completely interferes

Sleep

0	1	2	3	4	5	6	7	8	9	10
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Does not interfere Completely interferes

Enjoyment of Life

0	1	2	3	4	5	6	7	8	9	10
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Does not interfere Completely interferes

Ability to Concentrate

0	1	2	3	4	5	6	7	8	9	10
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Does not interfere Completely interferes

Appetite

0	1	2	3	4	5	6	7	8	9	10
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Does not interfere Completely interferes

What level of pain do you think you could function with on a daily basis?

0	1	2	3	4	5	6	7	8	9	10
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No Pain

Worst pain imaginable