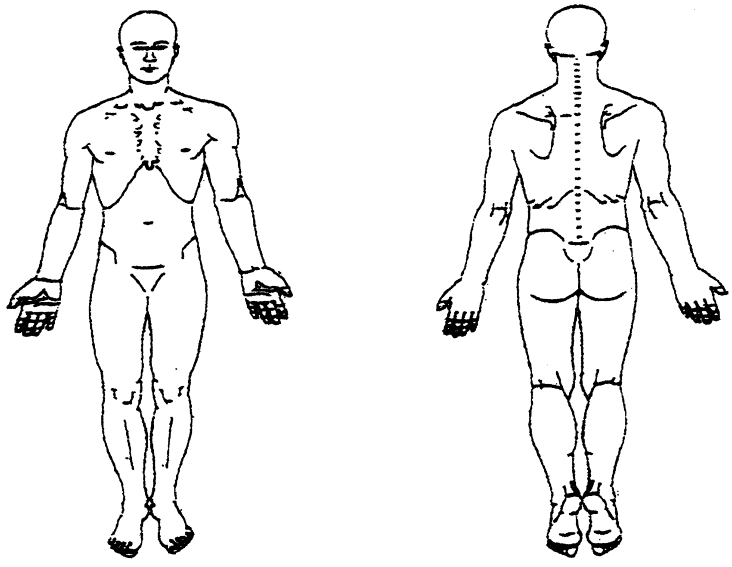
Pain Assesment

A. Where is the location of your pain? Please clearly mark on the diagram:



B. Please rate the level of your pain at present from a scale of 1-10(10 is the most severe)______________
C. What is the quality of your pain(ie. aching, burning, stabbing, dull)____
D. Pain is Constant_______YES ______NO
E. If pain is not constant than how often does it occur?____
F. How long have you had your pain?
_____Hours_____Days_____Weeks_____Months_____Years
G. Did the pain start gradually or suddenly?___________________________
H. Do any of the following lessen the pain?
_____Pressure_____Heat_____Cold_____Movement(Which movement)____
I. Do any of the following make the pain worse?
_____Pressure_____Heat_____Cold_____Movement(Which movement)____
J. Is there anything else that relieves your pain?____
K. Is there anything else that makes your pain worse?____
L. Please circle of your pain has had some effect on any of the following: sleep activity level emotions ability to concentrate appetite relationships
M. Please list or describe any prior treatments that you have had regarding your condition____
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