

# PAIN ASSESSMENT QUESTIONNAIRE

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Where does your pain begin? \_\_\_\_\_

1. Indicate on the drawings the location(s) of pain and radiation if present.

2. Date of pain onset: \_\_\_\_\_

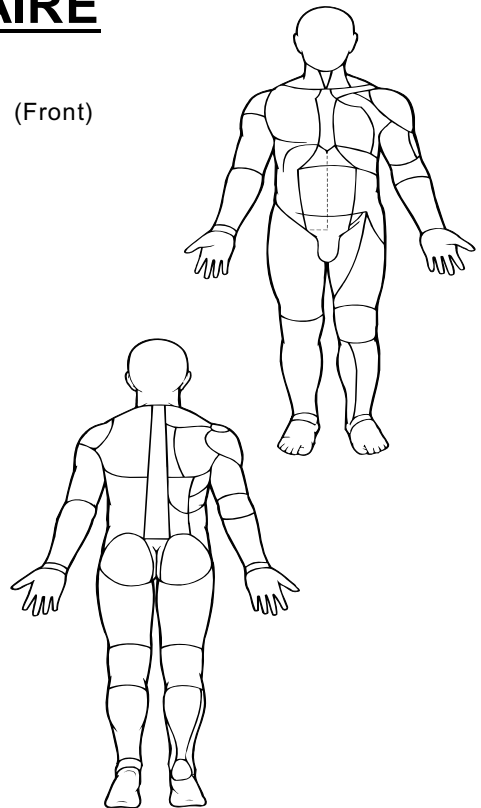
3. How often does it occur? \_\_\_\_\_

- Chronic     Intermittent

4. How long does it last? \_\_\_\_\_

5. Describe how the pain feels:

- Sharp     Aching     Throbbing     Stabbing     Burning  
 Tingling     Pressure     Wringing  
 Other \_\_\_\_\_



6. Severity: "On a scale of 0 to 10, with 0 being no pain and 10 being the worst possible pain, (see scale below)

6a. What number would you give your pain now? \_\_\_\_\_ Most severe in past 24 hours? \_\_\_\_\_

At your best (least pain)? \_\_\_\_\_

None		Annoying		Uncom- fortable		Dreadful		Horrible		Agony
0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain		Mod. Pain		Severe Pain		Very Severe Pain		Worst Possible Pain

7. Aggravating factors: "What makes your pain worse?"

8. Alleviating factors: "What makes your pain better?"

- Heat     Cold     Massage     Music     Distraction     Medication     Prayer     Meditation

Other:

9. Side effects currently experiencing with pain:

GI	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Loss of appetite
Nervous	<input type="checkbox"/> Drowsiness	<input type="checkbox"/> Confusion	<input type="checkbox"/> Hallucinations	
Emotional	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Mood Changes	
Other				

Who is completing this form?		
<input type="checkbox"/> Patient	<input type="checkbox"/> Interpreter	<input type="checkbox"/> Family Member:
<input type="checkbox"/> Office Staff		<input type="checkbox"/> Friend/Other: