

PAIN ASSESSMENT

Patient Name _____ Date _____

Chief Complaint 1. _____ 2. _____

Is your present problem due to an injury

On the job? Auto Accident? Personal Injury? Other _____

Did your pain begin Gradually? Suddenly?

Do you have pain All the time? Sometimes?

Is your pain worse when you

Sit Bend Walk Lift Push Pull Other _____

Which of the following areas do you have the most pain, discomfort or restriction of motion?

Neck Shoulders Arms Hands Upper Back Mid Back Low Back

Pelvis Hips Legs Knees Feet Other _____

IN AN 8 HOUR DAY RATE THE PERCENTAGE OF YOUR PAIN WHEN YOU:

Sit _____ % of the time

Stand _____ % of the time

Walk _____ % of the time

OCCASIONALLY = 33%

FREQUENTLY = 34-66%

CONTINUOUSLY = 67-100%

WHAT PERCENT OF YOUR TIME ARE YOU:

Housebound? _____ %

Chairbound? _____ %

Bedfast? _____ %

RATE THE SEVERITY OF YOUR PAIN BY CHECKING ONE BOX ON THE FOLLOWING SCALE

1 = LEAST PAIN
10 = EXTREME PAIN

EXTREME

10
9
8
7
6
5
4
3
2
1
0

NO PAIN

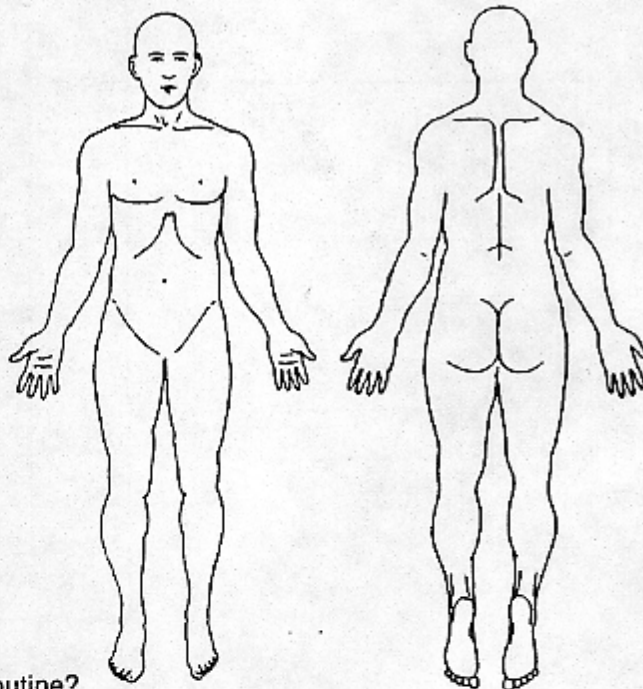
MARK AREAS OF PAIN ON THE FIGURES BELOW USING THESE CODES

+++ BURNING

000 STABBING

--- SHARP

||| CONSTANT



Does your pain interfere with your Work? Sleep? Daily Routine?

Do you feel your present condition is Temporary? Permanent? Don't know

List any additional comments you wish to make regarding your condition _____

Patient Signature _____