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

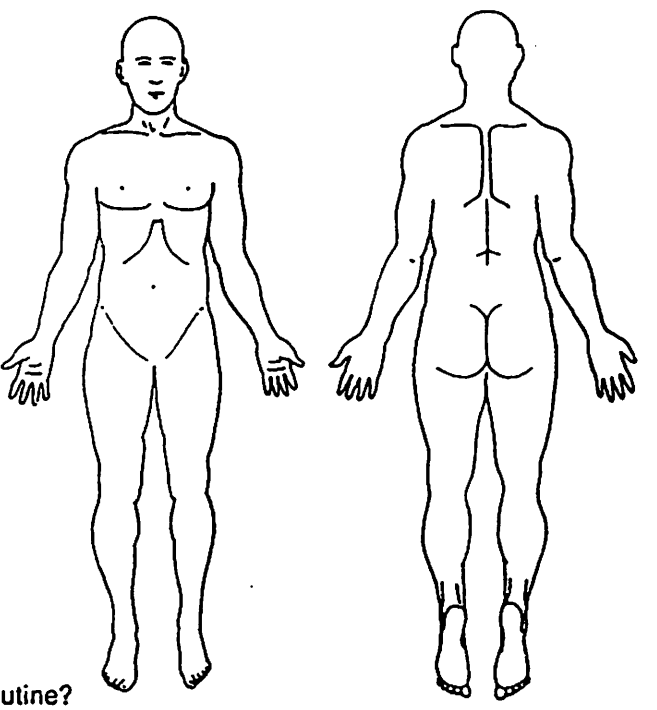
EXTREME

○	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 _____