

# Pain Assessment

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Onset: \_\_\_\_\_ How did this onset occur?: \_\_\_\_\_

If this is a new injury, how & where did it occur? \_\_\_\_\_

Has anything made your pain worse since your last visit \_\_\_\_\_

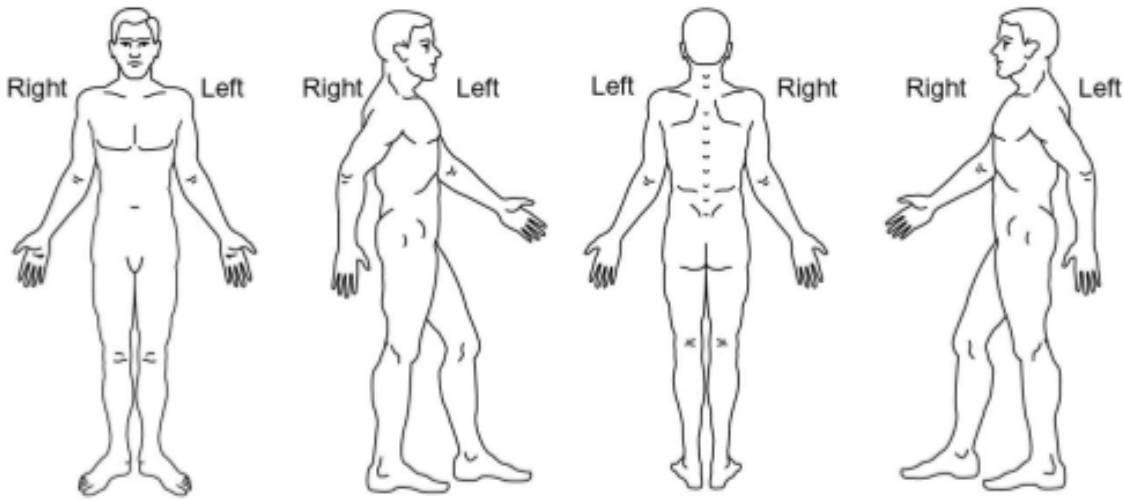
1. Please circle the letter(s) that corresponds with the type(s) of pain you are having:

**A = Ache B = Burning N = Numbness P = Pins & Needles**  
**S = Stabbing SP = Sharp SR = Sore D= Dull O = Other**

2. Please rate the severity of discomfort by circling the corresponding number on the following scale:

**0 \_\_\_\_\_ 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_ 7 \_\_\_\_\_ 8 \_\_\_\_\_ 9 \_\_\_\_\_ 10**  
**(0= No Pain, 5= Moderate Pain, 10=Severe Pain)**

3. Please mark an X on the picture where you are having pain:



Approximately what amount of your day are you experiencing this discomfort? (please circle one):

$\frac{1}{4}$  day       $\frac{1}{2}$  day       $\frac{3}{4}$  day      Constantly

Does it interfere with your (check all that apply)

Work \_\_\_\_\_, Sleep \_\_\_\_\_, Daily Routine \_\_\_\_\_, Other \_\_\_\_\_

Activities or Movements that aggravate the pain (check all that apply)

Sitting \_\_\_\_\_, Standing \_\_\_\_\_, Walking \_\_\_\_\_, Twisting/Turning, \_\_\_\_\_ Bending \_\_\_\_\_, Lying down \_\_\_\_\_  
Other \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_