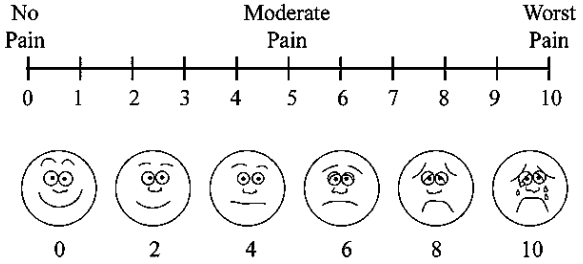
Pain Assessment Form

Name: _____
Date of Birth _____/_____/_____
MRN _____
T_____ P_____ R_____ B/P_____/____ Wt_____

1. Where is your pain located? _____
_____
2. When did your pain begin?_____
3. Does the pain radiate or travel to other areas?
_____
4. Is your pain: (*please check answer)*
☐ Intermittent ☐ Continuous ☐ Both?
5. Does your pain vary in intensity? ☐ Yes ☐ No
6. Does anything bring on or trigger your pain? _____
If so, what? _____
7. Was there an injury or accident that caused your pain?
_____
8. Please check the word(s) that descried your pain:

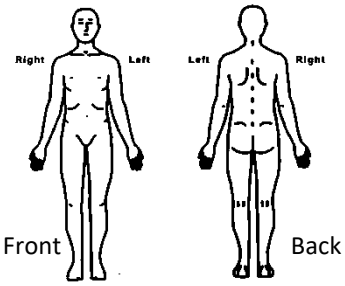
☐ Aching	☐ Throbbing	☐ Shooting
☐ Stabbing	☐ Gnawing	☐ Sharp
☐ Tender	☐ Burning	☐ Exhausting
☐ Tiring	☐ Penetrating	☐ Unbearable
☐ Numb	☐ Miserable	☐Squeezing
☐ Dull	☐ Radiating	☐ Knife-like
☐ Crampy	☐ Deep	

9. Rate the intensity of your pain:



10. What makes the pain feel better? _____
_____
_____
11. List any treatments (if Applicable) that you have received for your pain in the last year: _____
_____

Shade areas of pain



12. What other doctors have you seen for this problem?
_____
13. How does your pain affect your lifestyle? (↑, ↓ , no change)
Sleep_____ Appetite_____ Activity_____ Energy_____
14. Are you experiencing any other symptoms?
(*Check if applicable)*

☐ Nausea	☐ Sleepiness	☐ Weakness
☐ Vomiting	☐ Confusion	☐ Itching
☐ Constipation	☐ Difficulty urinating	
☐ Loss of bowel/bladder control		

15. Are you currently taking any blood thinners?
(i.e. Lovenox, Coumadin, Plavix, Aspirin)
☐ Yes ☐ No List: _____
16. Please list any allergies: _____
_____
17. Please list your current medications (including pain meds)
(*If known please list dosages)*
_____
_____
_____
_____
18. What non-steroidal anti-inflammatories have you used?
_____
_____
19. List Pharmacy Preference _____
20. Is there a chance you are pregnant? ☐ Yes ☐ No
Date of last Menses _____
21. Do you have any Mental Health Conditions?_____
_____
22. Family History of medical conditions: _____
_____
23. List Surgeries: _____
_____
24. Implants: (i.e. pacemaker, defibrillator) _____
_____

Medical History

Do you have or are you currently being treated for:

Anemia	Yes	No	Glaucoma	Yes	No	Seizures	Yes	No
Arthritis	Yes	No	Headaches	Yes	No	Stroke	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No	Street Drug Use	Yes	No
Back Problems	Yes	No	Hepatitis	Yes	No	Alcohol Use	Yes	No
Blood Disorder-Bruising	Yes	No	High Blood Pressure	Yes	No	Stomach Ulcers	Yes	No
Cancer	Yes	No	HIV	Yes	No	TB	Yes	No
Cataracts	Yes	No	Kidney Disease	Yes	No	Thyroid Disorders	Yes	No
Circulation Problems	Yes	No	Lunge Disease	Yes	No	Smoke (packs a day_____)	Yes	No
Diabetes	Yes	No	Osteoporosis	Yes	No	Other:		

Signature of person completing form _____ Date _____/_____/_____