Pain Assessment Sheet

I feel my pain is (circle all that apply):

Sharp  Burning  Tingling  Tearing  Dull  Cramping
Weakness  Aching  Mild  Stiffness  Discomfort  Tightness
Severe  Numbness  Other: ________________________________

Use the scale below to rate your pain (please circle):

0  1  2  3  4  5  6  7  8  9  10
None_________________________________________Intolerable

Type of pain you are rating: ________________________________

My pain is:
In the morning   Better   Worse   No Change
Bending forward   ___   ___   ___
Sitting in the car   ___   ___   ___
During mid-day   ___   ___   ___
Lying on my stomach   ___   ___   ___
Coughing/sneezing   ___   ___   ___
Prolonged sitting   ___   ___   ___
Prolonged standing   ___   ___   ___
Prolonged walking   ___   ___   ___

Please indicate areas of pain on the model below:
Mark areas with the following:  (Numbness = Lines____)  (Burning = Dashes----)  and  (Pain = xxxxx’s)
Medical History

Check all conditions that apply to you.

- [ ] Diabetes
- [ ] Hypertension
- [ ] Heart Disease
- [ ] Heart Attack
- [ ] Stroke
- [ ] High Cholesterol
- [ ] Irreg. heartbeat
- [ ] Chest Pain
- [ ] Anxiety
- [ ] Depression
- [ ] Stomach Ulcer
- [ ] Gastric Reflux
- [ ] Hepatitis
- [ ] Asthma
- [ ] Emphysema
- [ ] Kidney Stones
- [ ] Seizures
- [ ] Migraines
- [ ] Gout
- [ ] Arthritis
- [ ] Pass Out
- [ ] Head Injury
- [ ] Unusual Bleeding
- [ ] Blood Clots
- [ ] Colitis
- [ ] HIV
- [ ] Chron’s Disease
- [ ] Gallstones
- [ ] Cancer type: __________________ with ______ Chemotherapy____ Radiation____

Did you have surgical treatment and what type:

Please list all medications you currently are taking with dosages and frequency taken:

- ________________________________
- ________________________________
- ________________________________
- ________________________________
- ________________________________
- ________________________________
- ________________________________
- ________________________________

Medications allergies: Y__ N__ If yes, list of allergies: ________________________________

Prior surgeries: Y__ N__ If so, date: ________________________________

Do you smoke? Y__ N__ If yes, packs per day?____ Number of years?____

Do you drink alcohol? Y__ N__ Beer___ Wine____ Liquor____ # times per week____

Do you use recreational drugs? Y__ N__ Do you live alone? Y__ N__

Which is your dominant hand? Right ___ Left___ Both___

Height: _______          Weight: _______