



PAIN ASSESSMENT



DoctorsforPain.com

Patient's Name: _____

Date: _____

Circle areas where pain exist



1) When did pain first occur? _____

2) Was it caused by:

- | | |
|-------------------------|---------------|
| _____ Accident | _____ Cancer |
| _____ Illness | _____ Other |
| _____ Following Surgery | _____ Unknown |

3) How often do you have this pain? _____

4) Is pain _____ Continuous _____ Intermittent

5) Which of the following has an effect on your pain?

Write (1) if it helps pain and (2) if it makes pain worse

- | | | |
|----------------|----------------|------------------|
| _____ Anxiety | _____ Climate | _____ Cold |
| _____ Coughing | _____ Fatigue | _____ Heat |
| _____ Massage | _____ Noise | _____ Lying down |
| _____ Sitting | _____ Standing | _____ Walking |
| _____ Other | | |

6) Do you? _____ Smoke _____ Drink Alcohol _____ Caffeinated drinks

7) Check all that apply:

- Fatigue
- Nervousness
- Depression
- Insomnia
- Anxiety
- Headaches
- Numbness
- Leg Cramps
- Other _____

8) Is pain affected by certain activities?

Work/school	Yes/No	If yes explain: _____
Household Chores	Yes/No	If yes explain: _____
Social activities	Yes/No	If yes explain: _____
Leisure	Yes/No	If yes explain: _____
Sexual activity	Yes/no	If yes explain: _____

9) Are you currently employed? If not, explain _____

10) What treatments have you tried for your pain?

Acupuncture	_____	Biofeedback	_____
Brace	_____	Chiropractic	_____
Exercise	_____	Hypnosis	_____
Massage	_____	Nerve Blocks	_____
Physical Therapy	_____	Psychotherapy	_____
Relaxation	_____	Surgery	_____
Tens unit	_____	Trigger Point Inj.	_____
Other	_____		

11) What specialists have you seen?

Orthopedic Neurologist Neurosurgeon
 Psychiatrist Other

12) List name, address and telephone numbers of current physicians

1) _____
 2) _____
 3) _____

Patient's signature: _____ Date: _____