

APPT DATE: \_\_\_\_\_ APPT TIME: \_\_\_\_\_ ARRIVAL TIME: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ ACCT #: \_\_\_\_\_

DOB: \_\_\_\_\_ INSURANCE: \_\_\_\_\_

**Pain Scale**

**0-2 Short Term**      **3-4 Achy**      **5-6 Sharp**  
ex: sub a toe      ex: always there      ex: constant pain

**7-8 Pain that stops function**      **9 Intense**      **10 Torturing**  
ex: can't dress themselves      ex: sweating      ex: in ER  
Hospital

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. YES      2. NO

2) Where do you feel your pain?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3) Please rate your pain by circling the one number that best describes your pain at its LEAST in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
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No Pain      Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0	1	2	3	4	5	6	7	8	9	10
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No Pain      Pain as bad as you can imagine

5) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10
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No Pain      Pain as bad as you can imagine

6) Does your pain radiate from the area of maximum intensity, if so please describe from what area start to end. \_\_\_\_\_

\_\_\_\_\_

7) In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much RELIEF you have received.

0%	10	20	30	40	50	60	70	80	90	100%
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No Relief      Complete Relief

8) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

**A. General Activity**

0	1	2	3	4	5	6	7	8	9	10
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Does not interfere      Completely interferes

**B. Mood**

0	1	2	3	4	5	6	7	8	9	10
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Does not interfere      Completely interferes

**C. Walking Ability**

0	1	2	3	4	5	6	7	8	9	10
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Does not interfere      Completely interferes

**D. Normal Work (both outside the home and Housework).**

0	1	2	3	4	5	6	7	8	9	10
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Does not interfere      Completely interferes

**E. Relations with other people**

0	1	2	3	4	5	6	7	8	9	10
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Does not interfere      Completely interferes

**F. Sleep**

0	1	2	3	4	5	6	7	8	9	10
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Does not interfere      Completely interferes

**G. Enjoyment of life**

0	1	2	3	4	5	6	7	8	9	10
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Does not interfere      Completely interferes

In addition to comparing the pain inventory to help your doctor better manage your pain please tell us:

What does the pain feel like? Circle those words that describe your pain.
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