Pain Assessment

* *indicates a required field*

* Please describe your pain:

* Where is your pain originating from in your body?

Does your pain travel anywhere else?

* What do you think is causing your pain?

* How long have you been experiencing your pain?

* Is the pain occasional? If so, how often?

Yes

No

* Is the pain continuous?

Yes

No

Have you recently experienced a:

Motor vehicle accident

Worker's injury

Sports injury

Surgery

Other trauma

* What words best describe your pain?

Aching

Cramping

Burning

Shooting

Throbbing

Pressure

Electric shock

Numbing

Gnawing

Deep aching

Hot

Itching

Squeezing

Stabbing

Tingling

Other

* Do you have any other symptoms in addition to pain?

Yes

No

If applicable, please select all other symptoms that you're experiencing:

Sleep problems

Nausea

Itching

Irritability

Vomiting

Weakness

Loss of appetite

Constipation

Confusion

Difficulty urinating

Fear

Anxiety

Other

* Does your pain disturb any of the following?

Sleep

Walking

Concentration

Relationships

Eating

Housework

Energy

Enjoyment of life

Self-care

Work

Mood

Recreation

* Do you have a history of depression?

Yes

No

* Does the pain make you feel depressed?

Yes

No

* What have you tried to treat the pain?

Medications

Other treatment

This is my first time treating the pain

Do you have any medical problems/conditions?

Peptic ulcer disease

High blood pressure

Edema/swelling of legs

Kidney disease

Cancer

Other

* Do you have any allergies?

Yes

No