Follow-Up Pain Assessment Tool

Date:_____ Form completed by: _____

Information Source: ☐ Patient ☐ Spouse ☐ Child ☐ Interpreter ☐ Other

1. On the diagram to the right, circle **1** or **2** areas where you feel pain the most, and label them **A** and **B**.

2. Please check off all the words that describe your pain(s):
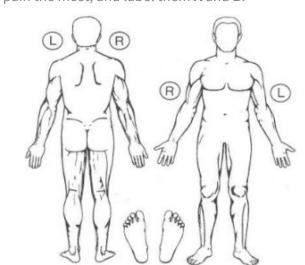
   NEUROPATHIC:

   ☐ Pins & Needles   ☐ Burning   ☐ Painful Cold

   ☐ Electric Shock   ☐ Itching   ☐ Numbness/Tingling
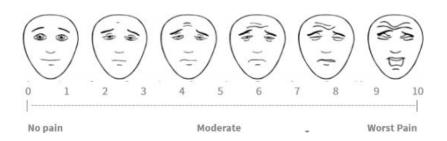
   NOCICEPTIVE:

   ☐ Dull Ache   ☐ Cramping   ☐ Throbbing

   ☐ Other _____

3. How long have you experienced pain **A** and/or pain **B**?

   PAIN A: _____ PAIN B: _____

4. Overall, how much pain are you experiencing?
   Circle the number that describes, overall, how much pain you are experiencing from 0 (no pain) to 10 (worst pain imaginable)

5. Using the 0-10 pain scale below, rate each of your pain(s) **in the last week:**

Scale 0-10	Pain A	Pain B
Pain at present		
Pain at its worst		
Pain at its least		
Pain on average		

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

6. Using the scale below, describe how your pain **in the last week** has interfered with:

0	1	2	3	4	5	6	7	8	9	10

    Does not interfere   Completely interferes

Activity	Number (0-10)
General activity	
Mood	
Walking ability	
Normal work (work outside the home and housework)	
Sleep	
Enjoyment of life	

7. What medications are you currently receiving for pain? Include dose and frequency.

    _____

    _____

    If you are taking medications for pain on an "as needed" basis, how much are you generally taking every day?

    _____

    Do these medications reduce your pain and how many hours do they work for?

    _____

8. Has the use of pain medications caused bothersome symptoms in the past? (Nausea, vomiting, constipation, drowsiness, dizziness, unclear thinking, change in mood, disturbed sleep, dry skin, other)

    _____

    _____

9. Health Professional comments including concerns of aberrant drug behaviors

    _____

    _____

    _____

10. Assessment reviewed by: _____

    Proposed management: _____

    Follow-up assessment scheduled for (date): _____