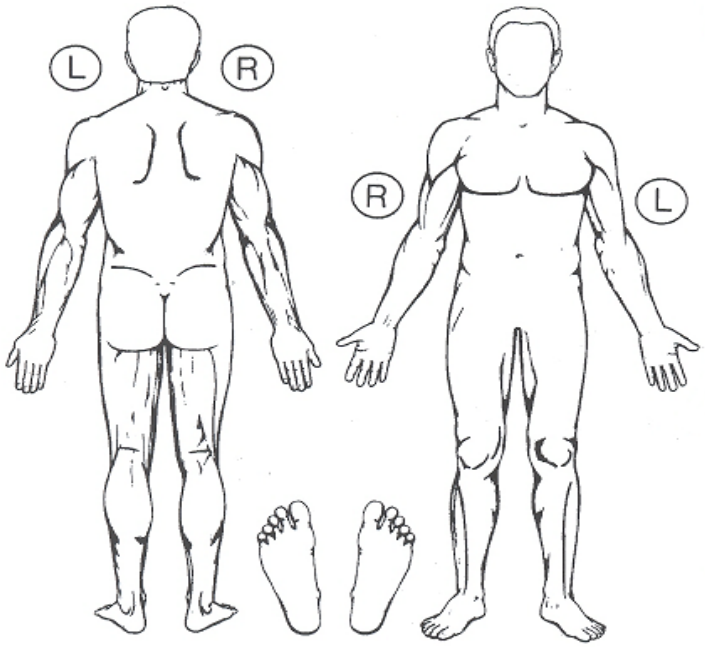
Initial Pain Assessment Tool

Date: _____ *(yyyy-Mon-dd)* Form completed by: _____

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

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

2. Circle the words that describe your pain(s). Write the letter A and/or B beside the describing word.



NEUROPATHIC

Pins & Needles
Burning
Painful cold
Numbness Tingling
Electric shock
Itching

NOCICEPTIVE

Dull ache
Cramping
Throbbing
Other _____

3. How long have you been having pain A and/or B?

Pain A _____ Pain B _____

4. How much pain are you having? Circle the number that describes overall how much pain you are having - from 0 (no pain) to 10 (worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

|----------|

No Pain Moderate Worst Pain

5. Using the 0-10 pain scale above, 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		
What makes your pain worse? (e.g. moving, eating)		
What makes your pain better? (e.g. heat, cold, lying still)		
How long does your pain last? (e.g. minutes, hours, constant)		

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)	
Relations with other people	
Sleep	
Enjoyment of life	

7. Check off your **3 most important goals** if you had less pain:

- ☐ Sleeping comfortably
- ☐ Comfort at rest
- ☐ Comfort with movement
- ☐ Stay alert
- ☐ Perform activity:
- ☐ Other (specify): _____

8. Circle where you think your pain level would need to be in order to reach these goals:

0 1 2 3 4 5 6 7 8 9 10
|----------|
No Pain Moderate Worst Pain

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

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

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

10. Besides medications, have you ever used any other therapies for your pain? (e.g. heat, cold, acupuncture, TENS, massage, splinting, relaxation, imagery, music, herbs, etc.)

11. What other medications or treatments have you tried to **reduce pain, but did not help**?

12. 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)

13. How often do your bowels move? _____

Are your stools Soft or Hard? _____

Current laxatives: _____

14. Health Professional comments:

(A) Assessment reviewed by _____

Who will be managing the patient's pain? _____

Proposed management (if known) _____

Follow-up assessment scheduled for _____ *(yyyy-Mon-dd)*

(B) Additional comments: