

Initial Pain Assessment

Name: _____ Date: _____

By answering the following questions, you will help your physician better understand and treat your pain.

When and how did your pain problem start? _____

As far as you know, what is the cause of your pain, i.e., the diagnosis? _____

What doctors have you seen? When did you see them? What did they do?

What was done? For example: Doctor did physical exam, ordered tests, prescribed medication.

Doctor's Name

Month/Year Seen

_____	_____	_____
_____	_____	_____
_____	_____	_____

What tests and studies have been done?

Tests & Studies

For example: MRI,

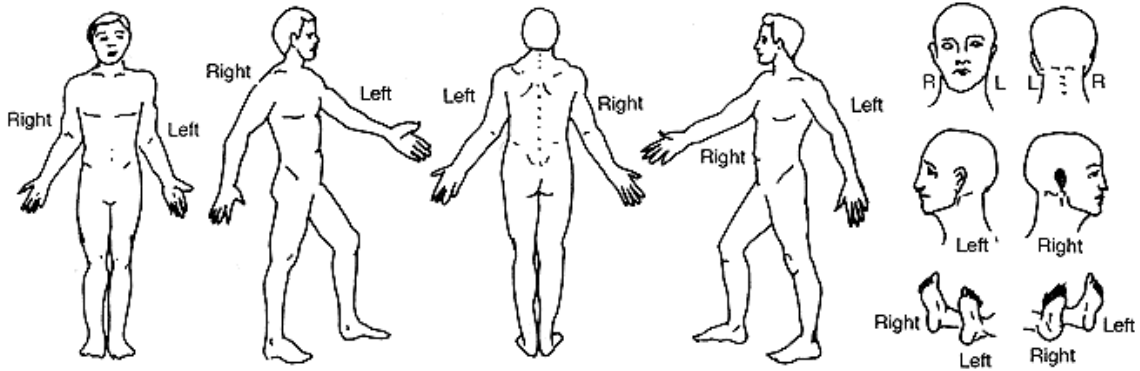
CT scan, X-rays

Month/Year Done

Results

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

On the diagram below, shade the area(s) where you feel pain. "X" the areas that hurt the most.



What pain treatments or medications are you receiving now - or have received in the past? (For example, pain medications, physical therapy, acupuncture, TENS, etc.) Circle the number next to the treatment to signify the amount of pain relief that treatment is providing or has provided.

Treatment or Medication	No Relief										Complete Relief	Check if Receiving Now
	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>
_____	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>
_____	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>
_____	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>
_____	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>
_____	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>
_____	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>
_____	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>

