Pain Assessment Form

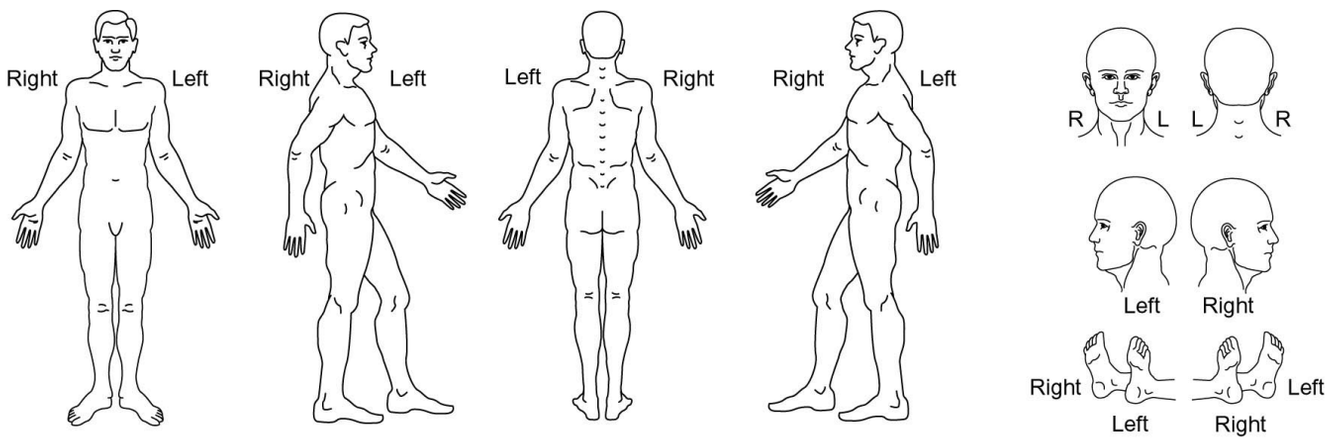
Date _____

Patient's Name _____ Age _____ Sex _____

Address _____ Phone No _____

Refering Doctor _____

1. LOCATION: Patient or nurse mark drawing.



2. INTENSITY: Patient rates the pain. Scale used _____

Present pain: _____ Worst pain gets: _____ Best pain gets: _____ Acceptable level of pain: _____

3. IS THIS PAIN CONSTANT? ____ YES; ____ NO IF NOT, HOW OFTEN DOES IT OCCUR? _____

4. QUALITY: (For example: ache, deep, sharp, hot, cold, like sensitive skin, sharp, itchy) _____

5. ONSET, DURATION, VARIATIONS, RHYTHMS: _____

_____ 6. MANNER OF EXPRESSING PAIN: _____

_____

7. WHAT RELIEVES PAIN? _____

_____ 8. WHAT CAUSES OR INCREASES THE PAIN? _____

_____

9. EFFECTS OF PAIN: (Note decreased function, decreased quality of life.)

Accompanying symptoms (e.g., nausea) _____

Sleep _____ Appetite _____

Physical activity _____ Relationship with others (e.g., irritability) _____

_____ Emotions (e.g., anger, suicidal, crying) _____

Concentration _____ Other _____

10. OTHER COMMENTS: _____

_____

11. PLAN: _____

_____

_____

Dr Krishna Poddar

MD &Fellowship Pain Management

(Senior consultant)

Belle Vue Pain & Spine Clinic

drpoddark@yahoo.co.in, wwwkolkatapainclinic.com