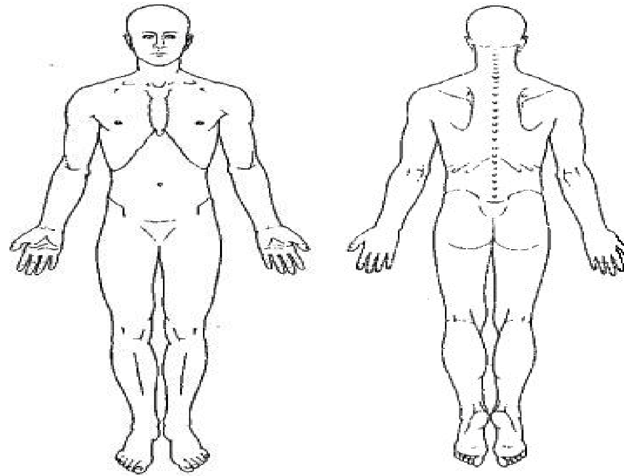
<u>Pain / Problem Assessment</u>

Name: ________________ Date: ___________________

Please indicate areas where you have pain or problems for which we will be treating you:



Nature of your pain problem? (i.e. sharp, shooting, dull, aching, throbbing, etc.)

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Severity of pain – on a scale of 0-10 with 0 being no pain and 10 being severe pain.

Rank Pain at its			
	WORST	__________	0 no pain
	BEST	__________	1-2 very little
	AVERAGE	__________	3-4 mild
			5-6 moderate
			7-8 a lot
			9-10 excruciating

<u>PAIN IS BEST WHEN I:</u>

Sit_____ Lie Down ______ stand ______ walk _______ other _______

<u>PAIN IS WORST WHEN I:</u>

Sit _____ Lie Down ______ stand ______ walk _______ other _______

How is the pain problem affecting your life? (i.e. hurts to walk etc.)

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Signature: ________________________