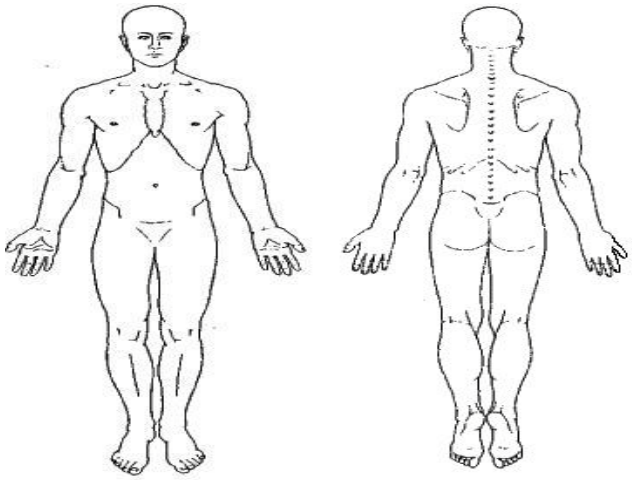
Pain / Problem Assessment

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.)

_____

_____

_____

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

PAIN IS BEST WHEN I:

Sit_____ Lie Down _____ stand _____ walk _____ other _____

PAIN IS WORST WHEN I:

Sit _____ Lie Down _____ stand _____ walk _____ other _____

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

_____

_____

_____

Signature: _____