Patient Pain Assessment

Name:Last				First				Date		
									Date	
				0-10 Numeri	c Pain Int	tensity Scale (1)			
0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain	-	Moderate Pain		Severe Pain	·	Very Severe	Intoleral Pain	-
1) Please ra 0 No Pain	ate your pain 1	by circling 2	g the one nu 3	umber that best of 4	describes y 5	our pain at its 6	WORST 7	in the past 2 8		0 e Pain
2) Please ra 0 No Pa	1	by circling 2	g the one nu 3	umber that best of 4	describes y 5	our pain at its 6	LEAST i	n the past 24	4 hours. 9 1 Intolerabl	
3) Please	rate vour pa	in by circli	ng the one i	number that bes	t describes	s vour pain on	the AVER	RAGE		
0 No Pa	1	2	3	4	5	6	7	8	9 1 Intolerabl	
4) Please	rate vour pa	in by circli	ng the one i	number that tells	s how muc	ch pain vou ha	ve RIGHT	ΓNOW		
0 No Pa	1	2	3	4	5	6	7	8	9 1 Intolerabl	0 e Pair
5) What tre	atments or r	nedications	are you rec	ceiving for your	pain?					
6) Circle th	e one numb	er that desc	ribes how, o	during the past 2	24 hours, p	oain has interfe	ered with	your:		
0	al activity 1 not Interfere	2	3	4	5	6	7	8	9 1 Completely Inte	
B. Walki	ng ability									
0 Does	1 not Interfere	2	3	4	5	6	7	8	9 1 Completely Inte	
C. Norm	al work (inc	ludes both	work outsid	le the home and	housewor	·k)				
0 Does	1 not Interfere	2	3	4	5	6	7	8	9 1 Completely Into	
D. Sleep										
	1 not Interfere	2	3	4	5	6	7	8	9 1 Completely Inte	
E. Enjoy	ment of life									
	1 ot Interfere	2	3	4	5	6	7	8	9 1 Completely Inte	0 erferes