Patient Pain Assessment

Name: _____ _____ _____

Last **First** **Date**

0-10 Numeric Pain Intensity Scale (1)

0	1	2	3	4	5	6	7	8	9	10
No Pain		**Mild Pain**		**Moderate Pain**		**Severe Pain**		**Very Severe**	**Intolerable Pain**	

1) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No Pain Intolerable Pain

2) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No Pain Intolerable Pain

3) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0 1 2 3 4 5 6 7 8 9 10

No Pain Intolerable Pain

4) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0 1 2 3 4 5 6 7 8 9 10

No Pain Intolerable Pain

5) What treatments or medications are you receiving for your pain? _____

6) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere Completely Interferes

B. Walking ability

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere Completely Interferes

C. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere Completely Interferes

D. Sleep

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere Completely Interferes

E. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere Completely Interferes