**PAIN ASSESSMENT**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s #: \_\_\_\_\_\_\_\_\_\_\_\_

Please mark the figures below with the letters that best describes the sensation or pain you are feeling. Please mark arrears where pain radiates or spread with an arrow 🡡, 🡣, 🡢 or 🡠 to indicate the direction of radiating pain.

(Include all affected areas)

**A** = Ache **B** = Burning **R** = Radiating Pain **D** = Dull Pain

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **0**No Pain | **1 2** Minimal | **3 4**Tolerable, but hinders Activities | **5 6**High - 50% of Activities Impaired  | **7 8**Extreme - most activities impaired | **9**Unbearable |

**N** = Numbness **S** = Stabbing **P** = Pins and Needles **O** = Other

**Next to each area, mark the intensity of pain:**



Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_