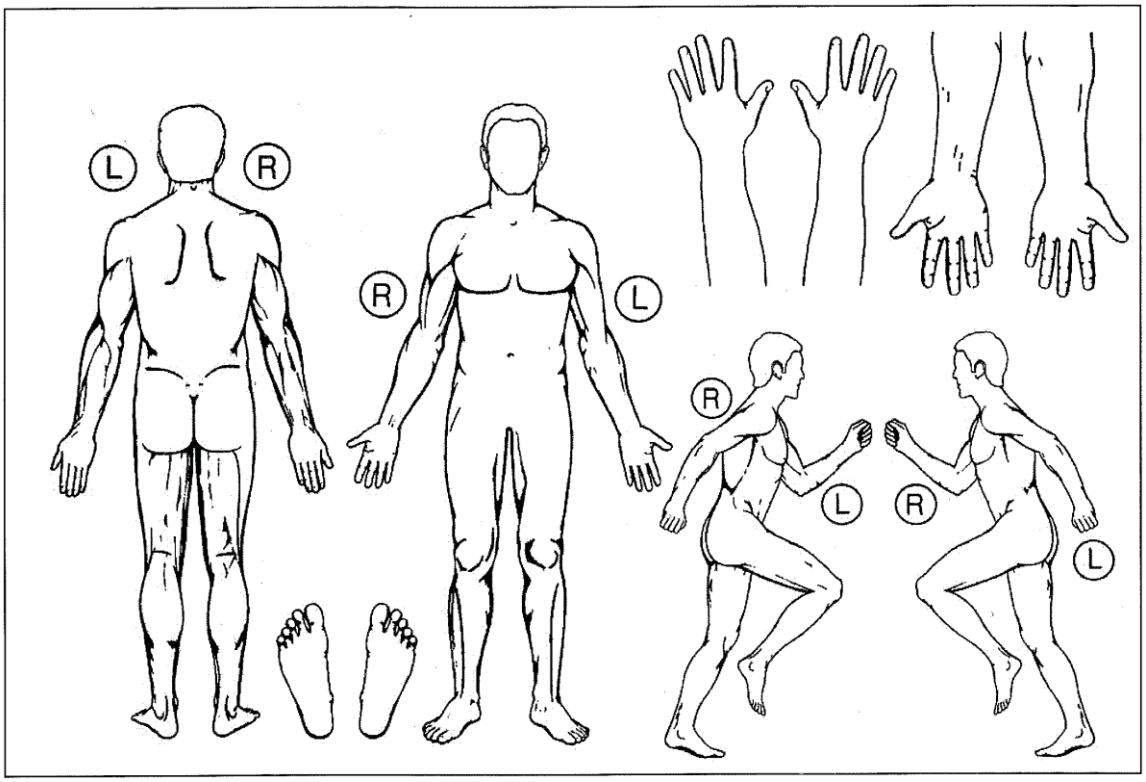
## *Patient Brief Pain Assessment*

Patient name: _____ PHN: _____

Date: _____ Date of birth: _____

*Completion of this questionnaire will help your physician with today's visit.*

1. If you have pain, indicate areas of your body where the pain is located.




2. Pain intensity – if you have multiple areas of pain – which area gives you the most pain or discomfort ?

_____

a. For this area of pain – please circle the one number that best describes your pain at its **worst** in the past 24 hours.

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst pain you can imagine |

b. For this area of pain – please circle the one number that best describes your pain at its **least** in the past 24 hours.

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst pain you can imagine |

c. For this area of pain – please circle the one number that best describes your pain on the **average**.

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst pain you can imagine |

*Turn over the page*

d. For this area of pain – please circle the one number that tells how much pain you have **right now**.

| No pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst pain you can imagine |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

3. What makes your pain **feel better**? _____

_____

_____

4. What makes your pain **feel worse**? _____

_____

_____

5. In the last 24 hours, how much relief have your pain treatments or medications provided? Please circle the one percentage that shows most how much **relief** you have received.

| No relief | 0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% | Complete relief |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

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

a. **General Self-Care Activities** (e.g., dressing, bathing, etc.):

| Does not interfere | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely interferes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

b. **Mood:**

| Does not interfere | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely interferes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

c. **Walking Ability:**

| Does not interfere | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely interferes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

d. **Normal work** (includes both work outside the home and housework):

| Does not interfere | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely interferes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

e. **Relations with other people:**

| Does not interfere | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely interferes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

f. **Sleep:**

| Does not interfere | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely interferes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

g. **Enjoyment of life**

| Does not interfere | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely interferes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

*Thank you for completing this questionnaire.*