WEST MICHIGAN ORTHOPAEDICS

PAIN ASSESSMENT

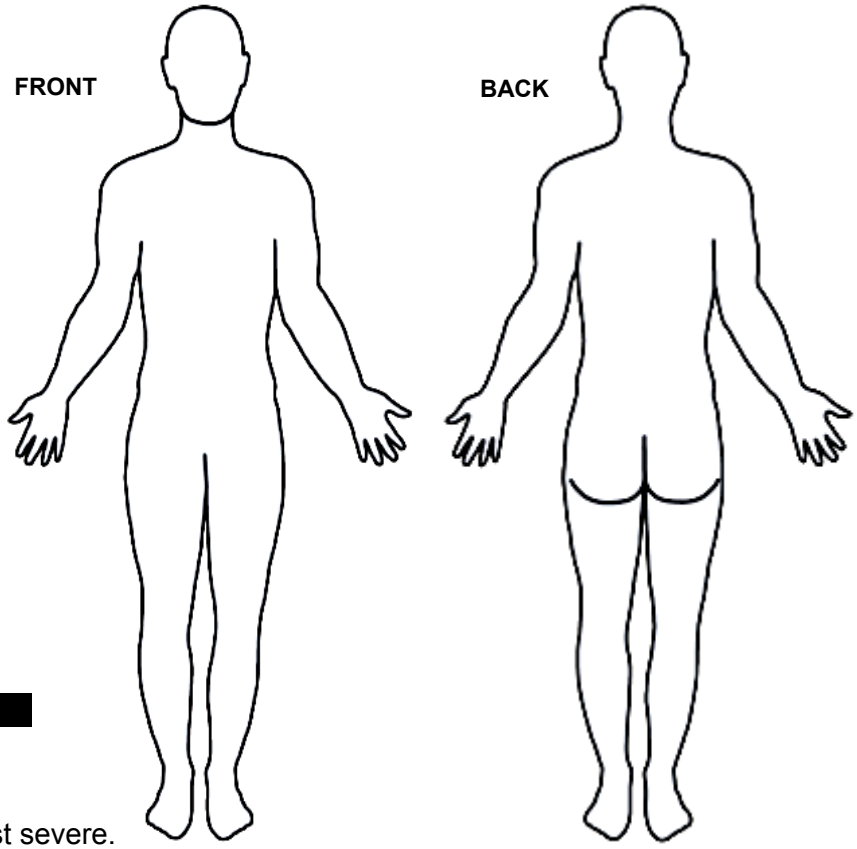
PATIENT _____ **DATE OF BIRTH** _____

PAIN DIAGRAM

Using the symbols below, mark the areas on your body where you feel the described sensation. Include all affected areas.

SYMBOLS:

Dull, Achy
///
Sharp, Stabbing
xxx
Electrical, Shooting
≈≈≈



PAIN SCALE

(0 = No Pain and 10 = Worst Pain Imaginable)

Circle the **range** of your pain from best to most severe.

0 1 2 3 4 5 6 7 8 9 10

Circle your **current level** of pain.

0 1 2 3 4 5 6 7 8 9 10

TREATMENT

What makes your pain **better**? _____

What makes your pain **worse**? _____

Have you tried:

- **Pain medication**? ❑ Y ❑ N
  If yes, which one? _____
- **Physical therapy**? ❑ Y ❑ N
  If yes, where and for how long? _____
- **Injection**? ❑ Y ❑ N
  If yes, when? _____ Was it temporarily helpful? _____