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Pain Assessment Form

Patient Name: _____
Date: _____
Provider: _____

Pain Score (0–10)

(0 = no pain, 10 = worst pain imaginable)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Pain Type (check all that apply)

☐ Acute ☐ Chronic ☐ Intermittent ☐ Constant ☐ Other: _____

Pain Location

Pain Radiating Towards

Pain Descriptors (check all that apply)

☐ Sharp ☐ Dull ☐ Throbbing ☐ Burning ☐ Tingling
☐ Stabbing ☐ Pressure ☐ Aching ☐ Numbness
☐ Other: _____

Pain Frequency

☐ Rare ☐ Occasional ☐ Frequent ☐ Constant

Interference with Function (check all that apply)

☐ Sleep ☐ Work ☐ Exercise ☐ Daily Activities ☐ Relationships
☐ Other: _____

Pain Onset

☐ Sudden ☐ Gradual ☐ Post-Injury ☐ Post-Surgery ☐ Unknown
☐ Other: _____

Clinical Progression

☐ Improving ☐ Worsening ☐ Stable ☐ Fluctuating

Aggravating Factors

☐ Movement ☐ Stress ☐ Standing ☐ Sitting ☐ Walking ☐ Lifting
☐ Other: _____

Pain Interventions Tried

☐ Rest ☐ Heat ☐ Ice ☐ Medication ☐ Physical Therapy
☐ Injections ☐ Surgery ☐ Other: _____

Response to Interventions

☐ No Relief ☐ Mild Relief ☐ Moderate Relief ☐ Significant Relief
☐ Complete Relief

Additional Notes:

Patient Attestation

I certify that the information I have provided above is true and accurate to the best of my knowledge.

Patient Signature: _____
Date: _____