Name: _____ **DOB: / /** **Today's Date: / /____**

How would you rate your pain **TODAY**?

0 1 2 3 4 5 6 7 8 9 10
Least Worst

What was your **range of pain** over the **last month**? Mark the scale **twice:** once for **least pain,** and then for **worst**.

0 1 2 3 4 5 6 7 8 9 10
Least Worst

Please respond to each question or statement by circling one number per row. In the past 7 days…

		Not at all	A little bit	Somewhat	Quite a bit	Very much
1	How much did pain interfere with your day to day activities?	1	2	3	4	5
2	How much did pain interfere with work around the home?	1	2	3	4	5
3	How much did pain interfere with your ability to participate in social activities?	1	2	3	4	5
4	How much did pain interfere with your enjoyment of life?	1	2	3	4	5
5	How much did pain interfere with the things you usually do for fun?	1	2	3	4	5
6	How much did pain interfere with your enjoyment of social activities?	1	2	3	4	5
7	How much did pain interfere with your household chores?	1	2	3	4	5
8	How much did pain interfere with your family life?	1	2	3	4	5

Please describe **how your pain affects your daily life by** answering these questions

1. Have you been to the emergency room, urgent care, or other health care practitioner for your pain since your last visit in this clinic? ☐ No ☐ Yes
2. Do you have an appointment with a health care practitioner for your pain? ☐ No ☐ Yes If yes, WHO?_____
3. Is your pain relief adequate? ☐ No ☐ Yes If no, please list specific goals that you feel have not been yet achieved on the reverse side of this paper.

MEDICATION

4. **PAIN RELIEF: On the average, by what percentage do your medications reduce your pain? (0% = no relief, 100% = complete relief)**

Please circle: 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

5. **Since your last visit with us have you experienced any of the medication side effects (circle any that apply):**

Nausea sweating drowsiness poor concentration shakiness increased joint pain

itching feeling drunk poor sex drive poor coordination flushing increased tiredness rash

dizziness new headache difficulty urinating constipation new or increased leg or foot swelling

Reviewed with the patient_____ MD, DO, NP, PA, RN