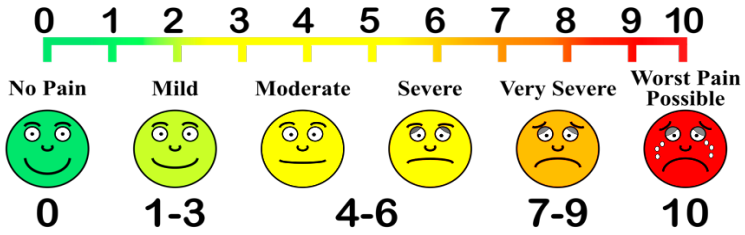
Striving to Thriving

Appendix 5 - Pain Descriptors and Assessment

This pain assessment provides the physician/therapist with specific information regarding your pain, such as location, quality, intensity, cause and location(s).

Name: _____ Date: ____/____/____ Pain Rating: _____



Today I present with:
- ☐ Chronic Pain
- ☐ Active Cancer
- ☐ Stable Cancer
- ☐ Inactive Cancer

I have the following device(s)
- ☐ Drug pump
- ☐ Stimulator

Describe your pain since your last visit.

Status	☐ Changing	☐ Improving	☐ Fluctuating	☐ Resolved	☐ Stable	☐ Worse
Severity	☐ Incapacitating	☐ Mild	☐ Mild-Moderate	☐ Moderate	☐ Moderate-Severe	☐ Severe

Your quality of life is: Improving Stagnant Decreasing

Common Pain descriptors:

** Describe in further detail below.

Primary Area of Pain	Pain Radiates to:	Quality of Pain	Original Cause/Context of Pain:
☐ Upper back	☐ None	☐ Ache	☐ Abuse
☐ Mid back	☐ Back	☐ Burning	☐ Bending over
☐ Low back	☐ Left ankle	☐ Cold/Frosty	☐ Blow from behind
☐ Gluteal area	☐ Left arm	☐ Deep	☐ Hard fall
☐ Left flank	☐ Left calf	☐ Diffuse	☐ Inflamed bowel
☐ Right flank	☐ Left foot	☐ Discomforting	☐ Lifting heavy object
☐ Arms L/R	☐ Left thigh	☐ Dull	☐ Lying down
☐ Legs L/R	☐ Left leg	☐ Localized	☐ Motor vehicle accident
☐ Neck	☐ Right ankle	☐ Numbness	☐ No injury
☐ Thighs L/R	☐ Right arm	☐ Piercing	☐ Pulling
☐ Calves L/R	☐ Right calf	☐ Sharp	☐ Pushing
☐ Feet L/R	☐ Right foot	☐ Shooting	☐ Sports
☐ Other**	☐ Right thigh	☐ Stabbing	☐ Stiff person syndrome
_____	☐ Right leg	☐ Superficial	☐ Sudden movement
_____	☐ Both legs	☐ Throbbing	☐ Surgery
	☐ Other **	☐ Other**	☐ Trauma
	_____	_____	☐ Twisting movement
	_____	_____	☐ Walking
			☐ Walking up stairs
			☐ Other **
			_____
			_____

Have you had any falls in the last year Yes No Did the falls result in injury Yes No
Number of falls: _____ if yes, Describe injury. _____

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Are you now experiencing any of the following Problems? If yes, please indicate **N**ew or **O**ngoing

	N	Y	New or Ongoing (N or O)		N	Y	New or Ongoing (N or O)		Y	Y	New or Ongoing (N or O)
Gastrointestinal				**Neurological**				**Musculoskeletal**			
Constipation				Extremity Numbness				Back Pain			
Nausea				Extremity Weakness				Joint Pain			
Vomiting								Neck Pain			
Genitourinary				**Psychiatric**							
Urinary Incontinence				Anxiety							
Urinary retention				Depression							
Urinary Frequency				Insomnia							

Comments:

Concerns:

Questions: