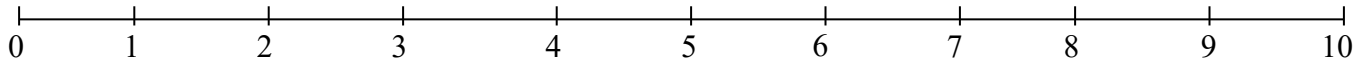
# Patient Pain Assessment

**Name:** _____ _____ _____

**Last** **First** **Date**

**0-10 Numeric Pain Intensity Scale (1)**




**No Pain** **Mild Pain** **Moderate Pain** **Severe Pain** **Very Severe** **Intolerable Pain**

1) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No Pain Intolerable Pain

2) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No Pain Intolerable Pain

3) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0 1 2 3 4 5 6 7 8 9 10

No Pain Intolerable Pain

4) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0 1 2 3 4 5 6 7 8 9 10

No Pain Intolerable Pain

5) What treatments or medications are you receiving for your pain? _____

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

**A.** General activity

**0 1 2 3 4 5 6 7 8 9 10**

Does not Interfere Completely Interferes

**B.** Walking ability

**0 1 2 3 4 5 6 7 8 9 10**

Does not Interfere Completely Interferes

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

**0 1 2 3 4 5 6 7 8 9 10**

Does not Interfere Completely Interferes

**D.** Sleep

**0 1 2 3 4 5 6 7 8 9 10**

Does not Interfere Completely Interferes

**E.** Enjoyment of life

**0 1 2 3 4 5 6 7 8 9 10**

Does not Interfere Completely Interferes