PAIN AND SYMPTOM ASSESSMENT

Patient: _____ Date: _____

PAIN

Please rate your pain on a scale of 0-10, where 0 would be no pain at all, and 10 would be the worst pain you can imagine.

Right now, my pain level is:	0 1 2 3 4 5 6 7 8 9 10
Yesterday, my pain level was:	0 1 2 3 4 5 6 7 8 9 10
Thinking of the last 30 days:	
My average level of pain was:	0 1 2 3 4 5 6 7 8 9 10
On a good day, my pain level was:	0 1 2 3 4 5 6 7 8 9 10
On a bad day, my pain level was:	0 1 2 3 4 5 6 7 8 9 10
Out of the last 30 days, I had:	
Average days:	[ ] 0-30
Good days:	[ ] 0-30
Bad days:	[ ] 0-30
My pain is worst (check one):	[ ] Morning [ ] Afternoon [ ] Evening [ ] Night/Bedtime [ ] No particular time it is worst

OTHER SYMPTOMS

Please rate your symptoms on a scale of 0-10, where 0 is no problem at all, and 10 is the worst it could possibly be.

Lightheadedness/balance problems:	0 1 2 3 4 5 6 7 8 9 10
Trouble thinking clearly:	0 1 2 3 4 5 6 7 8 9 10
Trouble sleeping:	0 1 2 3 4 5 6 7 8 9 10
Depression:	0 1 2 3 4 5 6 7 8 9 10
Trouble voiding (passing urine):	0 1 2 3 4 5 6 7 8 9 10
Constipation:	0 1 2 3 4 5 6 7 8 9 10
Are you having any other symptoms related to your pain or medicines?	[ ]Yes [ ]No
If yes, describe:	