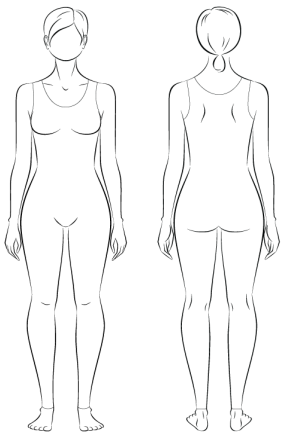
PAIN ASSESSMENT

Name _____ **Occupation** _____ **Date** _____

ANNAMAYA (THE PHYSICAL BODY)



Location: Where does it hurt?

Onset: When did it start hurting?

Quality: Describe the hurt...is it sharp, dull, achy, electric, numb, etc.?

Radiation: Does it radiate anywhere, like to an arm or leg?

Intensity: How bad is it (scale from one to ten)?

0	1	2	3	4	5	6	7	8	9	10
Pain Free	Very Mild	Discomfort-ing	Tolerable	Distressing	Very Distressing	Intense	Very intense	Utterly Horrible	Excruciating Unbearable	Unimaginable Unspeakable

No pain	**Minor Pain**	**Moderate Pain**	**Severe Pain**
Feeling perfectly normal	Nagging, annoying, but doesn't interfere with most daily activities.	Interferes significantly with daily living activities.	Disabling: unable to perform daily living activities. Cannot function independently.

When does it hurt the most? (time of day)

☐Upon waking up ☐Morning ☐Afternoon ☐Evening ☐Before bed ☐At night

What makes it hurt more?

What makes it hurt less?

ACTIVITIES

During the past 2 weeks, how much difficulty have you had doing your usual activities or tasks because of your physical and emotional health?

No difficulty	A little bit	Some difficulty	Much difficulty	Could not do

Which activities do you have trouble with?