OrthoTexas
Orthopedics & Sports Medicine

# PAIN ASSESSMENT TOOL

Name_____ Date_____

Date of Birth_____ Allergies to Medications_____

Blood Pressure_____ Pulse_____

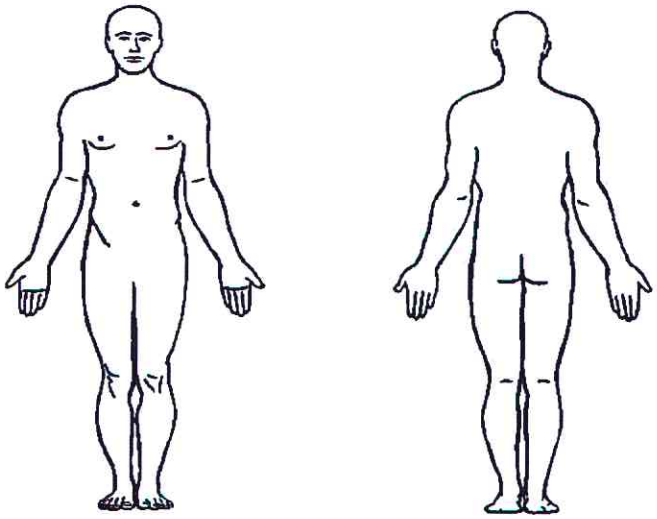
**Current Medications**
(Please list all current medications, prescription and over the counter, vitamins and herbal remedies).

_____

_____

**Where is your pain now? Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.**

| Aching | Numbness | Pins & Needles | Burning | Stabbing |
|---|---|---|---|---|
| ^^^ | === | ooo | xxx | /// |



**Rate your pain.** Circle the level of your pain today.

(No Pain)---------- (Worst Possible Pain)

0 1 2 3 4 5 6 7 8 9 10

**What words describe your pain? Please circle all that apply.**

| | | | |
|---|---|---|---|
| Aching | Stabbing | Tightness | Throbbing |
| Deep | Pressure | Squeezing | Cramping |
| Dull | Shooting | Burning | Sharp |