OrthoTexas
Orthopedics & Sports Medicine

Pain Assessment Tool

Name: _____ Date: _____
Date of Birth: _____ Height: _____ Weight: _____
Allergies to Medications: _____
Do you smoke cigarettes or vape? ☐ Yes ☐ No
Have you been exercising recently? ☐ Yes ☐ No
Do you have an Advanced Care plan? ☐ Yes ☐ No

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 symbols.

Aching	**Numbness**	**Pins & Needles**	**Burning**	**Stabbing**
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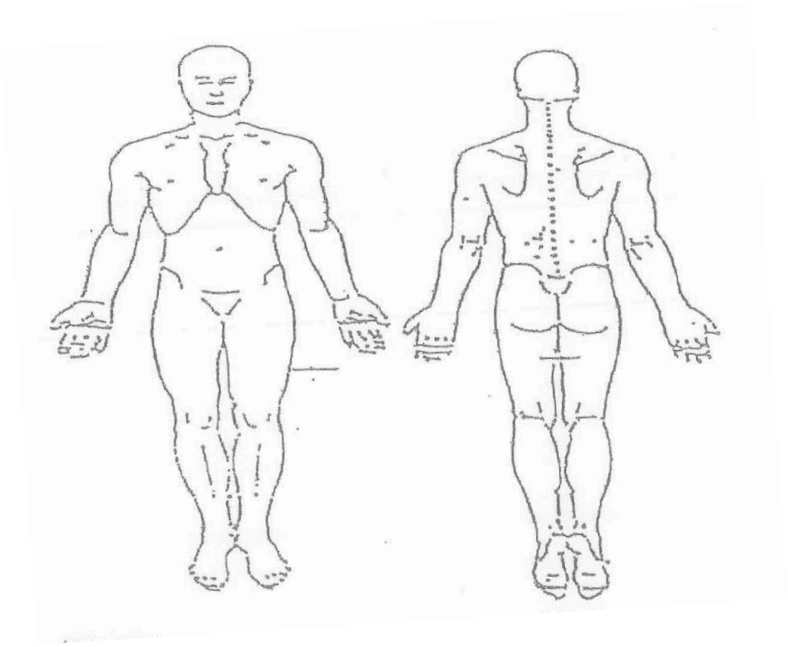

FRONT BACK

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. Examples include:

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