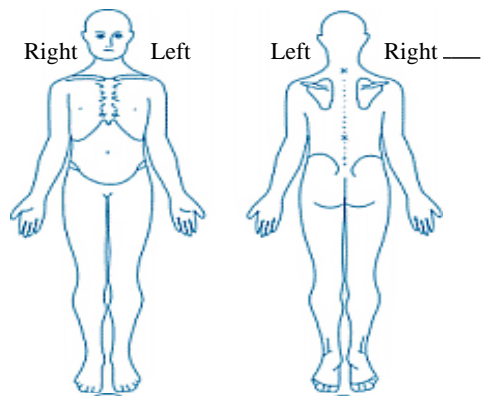


## PAIN QUESTIONNAIRE

Do you have pain now?  Yes  No

Have you had pain recently?  Yes  No

On the diagram below, please put an "X" on any area that hurts.



### Pain Description:

Dull: <input type="checkbox"/>	Throbbing: <input type="checkbox"/>
Sharp: <input type="checkbox"/>	Tender: <input type="checkbox"/>
Burning: <input type="checkbox"/>	Numb: <input type="checkbox"/>
Piercing: <input type="checkbox"/>	Cramping: <input type="checkbox"/>
Stabbing: <input type="checkbox"/>	Radiating: <input type="checkbox"/>
Heavy: <input type="checkbox"/>	Deep: <input type="checkbox"/>
Aching: <input type="checkbox"/>	Pressure: <input type="checkbox"/>
Crushing: <input type="checkbox"/>	Other: <input type="checkbox"/>

### Does Anything Make Your Pain Worse?

Deep Breathing:  Other:

Turning:  \_\_\_\_\_

Movement:  \_\_\_\_\_

Ambulation:  \_\_\_\_\_

Bright Lights:  Noise:

### What Makes the Pain Better?

Medications give good relief:

Quiet:  Darkness:

Other:

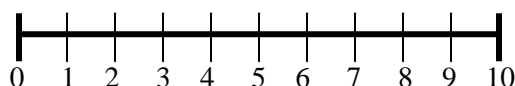
### How Long Have You Had This Pain? (circle one)

Less than a week                      1 or 2 weeks  
 2 or 4 weeks                              more than a month

### Do You Understand the Purpose of Pain Medication?

Yes  No

No                      Distressing                      Unbearable  
 Pain                      Pain                      Pain



### What Level of Pain Would Be Manageable For You?

Pain goal is \_\_\_\_\_ of 10

Pain goal is to be able to \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\*TO BE FILLED OUT BY NURSE\*\*\*\*\*

Diagnosis: \_\_\_\_\_ Significant Other: \_\_\_\_\_

**Patient Education Level:** Adult (18 or older) \_\_\_\_\_  
 Adolescent (13-17) \_\_\_\_\_  
 Pediatric (12 or less) \_\_\_\_\_

**Primary Language:** English \_\_\_\_\_  
 Spanish \_\_\_\_\_  
 Other \_\_\_\_\_

### Potential Barriers to Learning: (Pt-Patient, P-Parent, S-Significant Other)

None _____	Medical Condition _____	Hearing _____	Religious _____
Language _____	Mental Condition _____	Emotional _____	Cultural _____
Other _____			

**Motivation to Learn:** Low    Medium    High

**Method of Instruction:** Audio    Visual    Other

Nurse's Signature: \_\_\_\_\_

PATIENT IDENTIFICATION	
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Please read "What Is Pain" before completing this form.

Date: \_\_\_\_\_

