CT FamilyMedicine

Pain Evaluation

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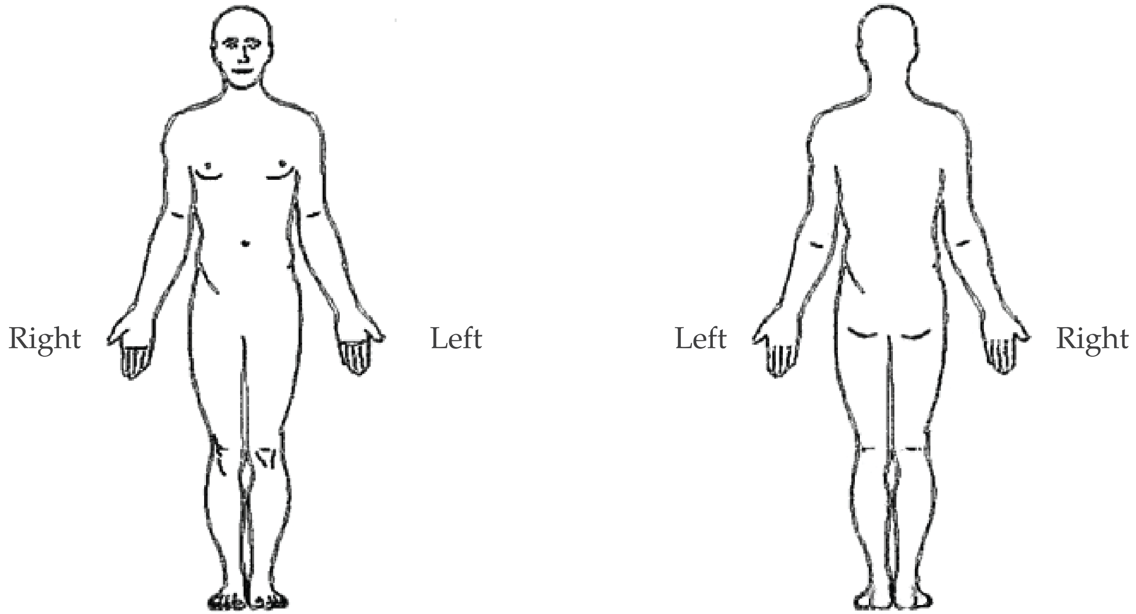
Name:_______________________________ **Date:**__________________

WHERE IS YOUR PAIN? Please mark all painful areas on the diagram below.



INTENSITY: How bad is the pain? (*Circle the appropriate number: 0 = no pain - 10 = worst pain***)**

0 1 2 3 4 5 6 7 8 9 10

PAIN CHARACTERISTICS: (*check all that apply***) Sharp___ Dull___ Burning___ Aching___**

Pressure___ Pins and Needles___ Other ____

WHEN DID THIS START? (*Approximately***)**____

WHAT DO YOU THINK HAPPENED TO CAUSE IT? ____
____

WHAT MAKES IT WORSE? ____

TIMING: Constant?____ Worse during: morning?____ afternoon?____ evening? ____ night?____