Invasive Pain Management/Anesthesia

RIGHT SIDE

LEFT SIDE

RIGHT SIDE

LEFT SIDE

RIGHT SIDE

LEFT SIDE

Draw the area of your pain.

1. How and when did your pain start?

2. Were is your pain?

3. Circle the words that describe your pain.

Indisposition	throbbing	sharp	stinging
acute	sore	burning	exhaustive
penetrating	constant	drowsy	fatigue
Miserable	unbearable	impaired	

Circle one:
Casual continual

At what time of the day is your pain worst?
Morning
Mid day
Afternoon
Night

4. Circle the number that better describes your worst pain in the past month:
No pain 0 1 2 3 4 5 6 7 8 9 10 worst imaginable pain

5. Circle the number that better describes your minor pain in the past month:
No pain 0 1 2 3 4 5 6 7 8 9 10 worst imaginable pain

6. Circle the number that better describes your most common pain in the past month:
No pain 0 1 2 3 4 5 6 7 8 9 10 worst imaginable pain

7. Circle the number that better describes your pain at this moment:
No pain 0 1 2 3 4 5 6 7 8 9 10 worst imaginable pain

8. What helps your pain get better?

9. What makes it worst?

10. What type of treatments or medications are you currently using?

Physical therapy chiropractic medication epidural injections

Circle the number that provides the kind of relief you get from your treatment or medication
a) No relief 0 1 2 3 4 5 6 7 8 9 10 total relief
Treatment or medication (doses included) ____

b) No relief 0 1 2 3 4 5 6 7 8 9 10 total relief
Treatment or medication (doses included))
____

c) No relief 0 1 2 3 4 5 6 7 8 9 10 total relief
Treatment or medication (doses included) ____

d) No relief 0 1 2 3 4 5 6 7 8 9 10 total relief
Treatment or medication (doses included) ____

11. What type of secondary effects or symptoms are you experiencing? Circle the one that best describes your experience for the past week.

nausea	vomit	constipation	lost of appetite	fatigue
itch	nightmares	sweat	concentration	insomnia

12. Circle the number that describes how the pain interfered with you on the past week.

a. General activity
Non 0 1 2 3 4 5 6 7 8 9 10 Completely

b. Mood
None 0 1 2 3 4 5 6 7 8 9 10 Completely

c. Normal work
None 0 1 2 3 4 5 6 7 8 9 10 Completely

d. Sleep
None 0 1 2 3 4 5 6 7 8 9 10 Completely

e. Enjoying life
None 0 1 2 3 4 5 6 7 8 9 10 Completely

f. Ability to focus
Non 0 1 2 3 4 5 6 7 8 9 10 Completely

g. Relationships
Non 0 1 2 3 4 5 6 7 8 9 10 Completely