CLEVELAND BACK AND PAIN MANAGEMENT CENTER, INC.
JOHN H. NICKELS, M.D.

INITIAL PAIN ASSESSMENT

Patient Name _____ **Date** _____

By answering the following questions, you will help your physician better understand and treat your pain.
When and how did your pain problem start?

_____

_____

_____

_____

As far as you know, what is the cause of your pain (ie, the diagnosis)? _____

_____

_____

_____

What doctors have you seen? When did you see them? What did they do? (for example: Doctor did physical exam, ordered tests, prescribed medication)

Doctor's Name	**Month/Year Seen**	**What Was Done**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What tests and studies have been done?
(for example: MRI, CT-Scan, X-Rays)

	Month/Year Done	**Results**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable
Intermittent	Continuous	

Circle the number that best describes your pain at its worst during the last month.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

Circle the number that best describes your pain at its least during the last month.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

Circle the number that best describes your pain on average during the last month.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

Circle the number that best describes your pain right now.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

What sort of things make this pain feel better (for example: heat, rest, medicine)?

_____

_____

_____

_____

What sort of things make this pain feel worse (for example: walking, standing, lifting)?

_____

_____

_____

_____

Circle the numbers below that best describe how pain has interfered with your daily functioning.

General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes	

Mood

0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes	

Walking Ability

0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes	

Normal Work Routine

0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes	

Relationships With Other People

0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes	

Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes	

Enjoyment of Life

0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes	

Ability to Concentrate

0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes	

Appetite

0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes	

What level of pain do you think you could function with on a daily basis?

0	1	2	3	4	5	6	7	8	9	10
No Pain									Worst pain imaginable	