

BROOKSWOOD CHIROPRACTIC

Patient Pain Assessment

Patient Name: _____ Date: _____ Case #: _____

1. Please rate your pain by circling the one number that best describes your pain at its **WORST** in the past week.

0 1 2 3 4 5 6 7 8 9 10
NO PAIN PAIN AS BAD AS YOU CAN IMAGINE

2. Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the past week.

0 1 2 3 4 5 6 7 8 9 10
NO PAIN PAIN AS BAD AS YOU CAN IMAGINE

3. Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**.

0 1 2 3 4 5 6 7 8 9 10
NO PAIN PAIN AS BAD AS YOU CAN IMAGINE

4. Please rate your pain by circling the one number that tells how much pain you have **RIGHT NOW**.

0 1 2 3 4 5 6 7 8 9 10
NO PAIN PAIN AS BAD AS YOU CAN IMAGINE

5. Circle the one number that describes how during the past week, **PAIN HAS INTERFERED** with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10
DOES NOT INTERFERE COMPLETELY INTERFERES

B. Mood

0 1 2 3 4 5 6 7 8 9 10
DOES NOT INTERFERE COMPLETELY INTERFERES

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10
DOES NOT INTERFERE COMPLETELY INTERFERES

D. Normal work (includes work both outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10
DOES NOT INTERFERE COMPLETELY INTERFERES

E. Relationships with other people

0 1 2 3 4 5 6 7 8 9 10
DOES NOT INTERFERE COMPLETELY INTERFERES

F. Sleep

0 1 2 3 4 5 6 7 8 9 10
DOES NOT INTERFERE COMPLETELY INTERFERES

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
DOES NOT INTERFERE COMPLETELY INTERFERES

6. What treatments or medications are you receiving for your pain? _____

For Office Use Only

of TX's _____