

HEALTH STARTS WITHINhere to help with Pain

Name of patient:-.....Consultation date:-...../...../.....

PAIN ASSESSMENT CHART

Please indicate with a tick at the side of the box specifying those pains you feel. If you sense any other type of pain please enter the detail in the spaces along the bottom row. If you are able to give any level of intensity then use a number on a scale of 1-10 scale (1=mild to 10=severe) in the column at the side of the pain description.

ACHING		DRAGGING		ITCHING		PRESSING		STABBING	
BITING		DRAWING		LANCINATING		PRICKING		STINGING	
BORING		DULL		NEURALGIC		PULLING		TEARING	
BURNING		FLEETING		NIGGLING		RADIATING		THROBBING	
CONSTRICTING		GNAWING		NUMB		RAW		THUMPING	
CRAMPING		GRIPING		PARALYTIC		SHARP		TIGHT	
CUTTING		JABBING		PIERCING		SORE		TWISTING	
DEEP		JERKING		PINCHING		SQUEEZING		WANDERING	
DIGGING									

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