# *Comprehensive Pain Management Center*

## PATIENT COMFORT ASSESSMENT GUIDE

**NAME: _____ DATE: _____**

**1. Where is your pain? _____**
**2. Circle the words that describe your pain.**

| | | |
|---|---|---|
| Aching | Sharp | Penetrating |
| Throbbing | Tender | Nagging |
| Shooting | Burning | Numb |
| Stabbing | Exhausting | Miserable |
| Gnawing | Tiring | Unbearable |

**Circle one:** Occasional Continuous

**What time of day is your pain the worst?**
Morning Afternoon Evening Nighttime

**3. Rate your pain by circling the number that best describes your pain at its <u>worst</u> in the last month.**
No pain 1 2 3 4 5 6 7 8 9 10 pain as bad as you can imagine

**4. Rate your pain by circling the number that best describes your pain at its <u>least</u> in the last month.**
No pain 1 2 3 4 5 6 7 8 9 10 pain as bad as you can imagine

**5. Rate your pain by circling the number that best describes your pain on <u>average</u> in the last month.**
No pain 1 2 3 4 5 6 7 8 9 10 pain as bad as you can imagine

**6. Rate your pain by circling the number that best describes your pain <u>right now.</u>**
No pain 1 2 3 4 5 6 7 8 9 10 pain as bad as you can imagine

**7. What makes your pain better? _____**

**8. What makes your pain worse? _____**

**9. What <u>treatments</u> or <u>medicines</u> are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide(s) you.**

**a) _____ no 1 2 3 4 5 6 7 8 9 10 complete**
**Treatment or medicine relief relief**

**b) _____ no 1 2 3 4 5 6 7 8 9 10 complete**
**Treatment or medicine relief relief**

**c)_____ no 1 2 3 4 5 6 7 8 9 10 complete**
**Treatment or injection relief relief**

**d) _____**
**How long did injection last**