DISPENSARIES

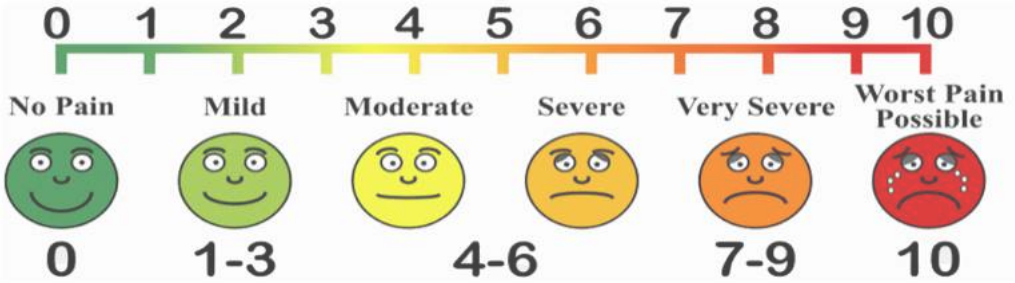
Pain Assessment

Name:		DOB:	DD/MM/YY	Age:	
Indicate:		Height:		Weight:	
Allergies:					

Was there a specific cause or incident that initiated your current pain complaint? If so please specify:					
Accident	Work injury	Surgery	Sport	Physical/Mental Trauma	Other:

As far as you can remember, how long have you had this pain?

What is the severity of your pain most days? (*on a scale of 1-10)*



How often do you have your pain:			
Constantly (100% of time)	Nearly Constantly (60%-80% of time)	Intermittently (30%-60% of time)	Occasionally (<30% of time)

Is there a certain **position/activity/temperature** that makes the pain **WORSE?**			
Sitting	Standing	Lying Down	Walking
Exercise	Lifting	Heat	Cold
Other:			

Is there anything that **HELPS** to relieve your pain?			
Heat	Cold	Massage	Stretching
Sleep	Medication	Other:	

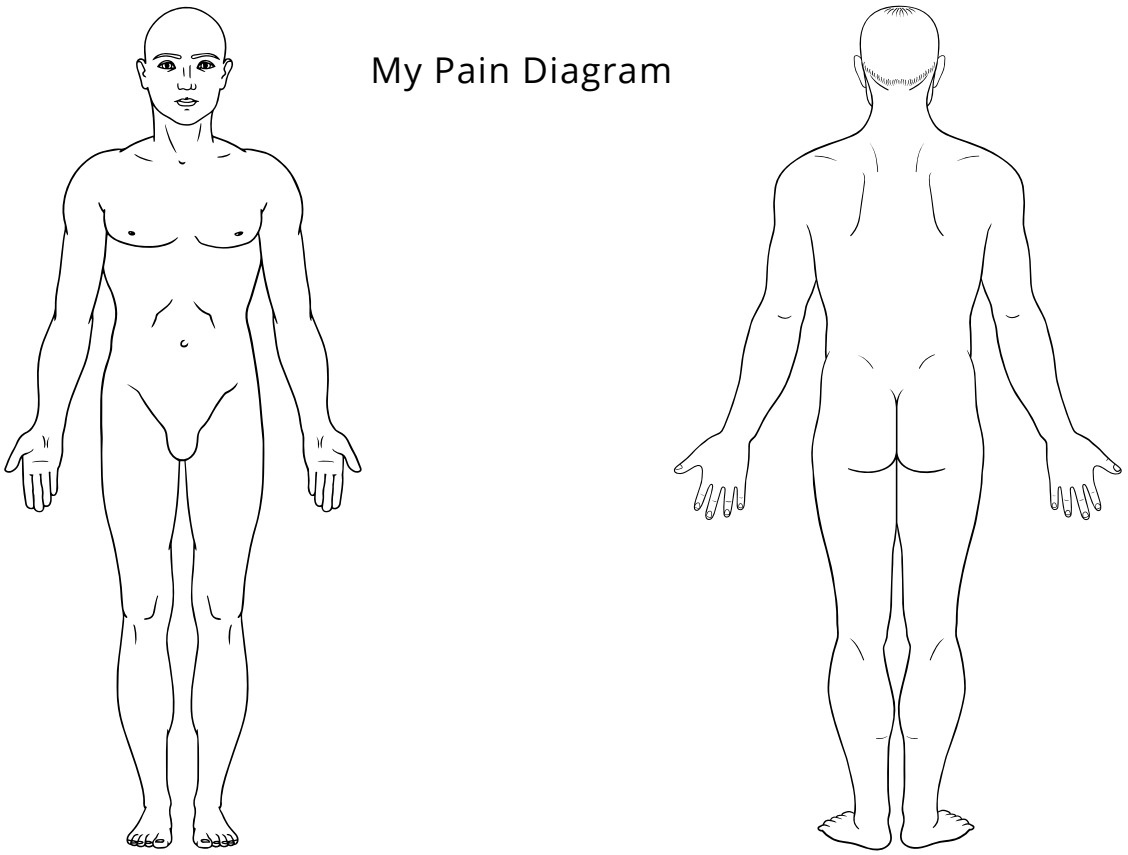
Please indicate by circling any pain treatments you have tried or are currently using:			
Physical therapy	Cognitive Behaviour Therapy	Hypnosis	Acupuncture
Nerve Block	Spinal Cord Stimulator	Surgery	Rehabilitation
Medication	Trigger Point Injections	TENS unit	Chiropractor
Biofeedback	Massage Therapy		

Have you tried any vitamins/supplements, herbs or other natural products? (*specify product, dose, duration and effect)*

Have you tried any lifestyle changes such as smoking cessation, alcohol reduction/abstinence, dietary changes, or exercise? (*Specify which measures, their duration and success)*

Can you indicate the areas or regions of pain on your body, **where would they be and what would it look like?**
Please shade areas of pain (may use colours to indicate intensity/sensation, or drawings such as needles, flames or arrows etc,)

My Pain Diagram



PHARMACY USE ONLY			
Pharmacist to attach any medication list collected from patient (including Rx, OTC, supplements). If possible indicate which pain medications have HELPED.			
Indicate therapeutic goals from his assessment, including any recommendations and follow up timelines:			
Patient Signature:		Pharmacist Signature:	
Date:			