

**COMPREHENSIVE PAIN ASSESSMENT FOR OVERALL BODY PAIN**

**Date** \_\_\_\_\_

**Patient name** \_\_\_\_\_

\_\_\_\_\_ **WITH PAIN (1125F)**                      \_\_\_\_\_ **WITHOUT PAIN (1126F)**

**IF pain present where is it Located:** \_\_\_\_\_

**Scale, from 1 to 10. How is your pain today:** 1 2 3 4 5 6 7 8 9 10

**Are you taking medications for pain, write the name**  
\_\_\_\_\_

**Quality (ache, burn, sharp, dull, etc.)**

**Onset** \_\_\_\_\_ **Duration** \_\_\_\_\_ **Variation** \_\_\_\_\_

**Alleviating, aggravating factors:** \_\_\_\_\_

**Affect on quality of life (ADLs, emotions, concentration, etc)** \_\_\_\_\_

\_\_\_\_\_  
**Physician signature**