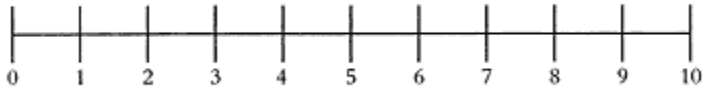
KANSAS SPINE & SPECIALTY HOSPITAL
INITIAL PAIN ASSESSMENT

Dear Patient,

As part of our pain management program, it is very important to our hospital to continually look for ways to provide better comfort measures that reduce the amount of pain and suffering associated with illness and/or surgery. We appreciate your time in completing this initial assessment which will assist us in individualizing your pain management during your hospital stay.

Name: _____ **Date:** _____

1. **Rate your pain by circling the number on a scale of 0-10 that best describes your pain on the average (0= no pain, 10 = pain as bad as you can imagine).**

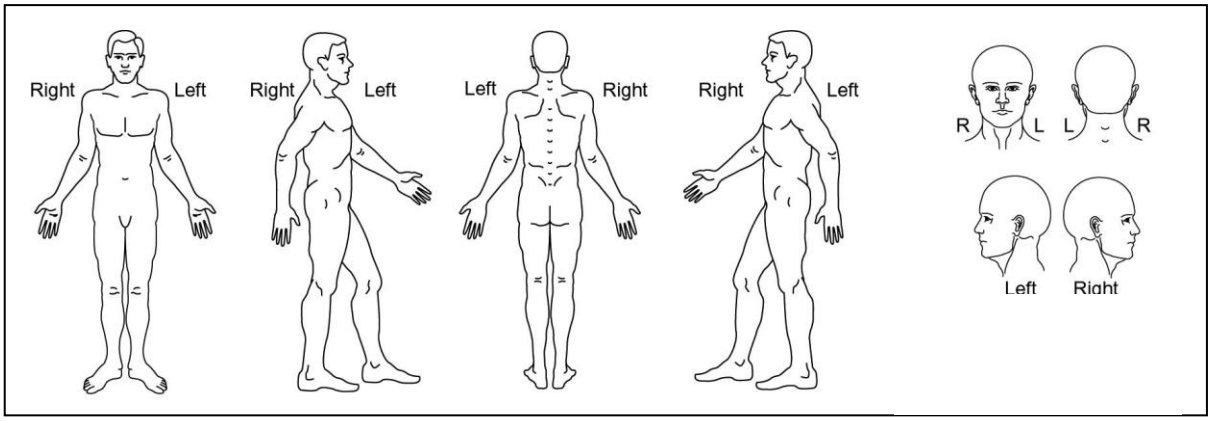


No Pain Worst Pain

2. **How much pain are you in right now?**

No Pain Worst Pain

3. **On the following diagram place an "X" over the area that best shows where your current pain is located.**



4. **Describe your pain here:**_____
Or, circle the words that best describe your pain: (Circle all that apply)

Aching	Sharp	Penetrating	Gnawing	Hot
Throbbing	Tender	Nagging	Tiring	Dull
Shooting	Burning	Numb	Unbearable	Squeezing
Stabbing	Exhausting	Miserable	Cutting	Tearing

5. **Is your pain:** (Circle one)

Occasional Continuous

6. **What time of the day is your pain the worst?** (Circle one)

Morning Afternoon Evening During the night

7. **Rate what is an *acceptable* level of pain for you:**

No Pain Worst Pain

10. **What kinds of things make your pain better?** (for example; heat, cold, medicine, rest) _____

11. **What kinds of things make your pain worse?** (for example; walking, bending, standing) _____

13. **I prefer to take my medications:**

- ☐ On a regular basis
- ☐ Only when necessary
- ☐ I do not take pain medications

14. **In a 24 hour period, I take my pain medications:**

- ☐ Not every day
- ☐ 1 to 2 times a day
- ☐ 3 to 4 times a day
- ☐ 5 to 6 times a day
- ☐ More than 6 times a day

15. **Do you feel you often need to take more of the pain medication than your doctor has prescribed?** (Circle one)

Yes No Unsure

16. **Medications not prescribed by my doctor that I take for pain are:**

_____

17. **Are you having problems with side effects from taking your pain medication(s)?** (Circle one)

Yes No Unsure

If yes, which side effect(s): (Check all that apply)

- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Lack of appetite
- ☐ Tired
- ☐ Itching
- ☐ Nightmares/hallucinations
- ☐ Sweating
- ☐ Difficulty thinking/concentrating
- ☐ Insomnia
- ☐ Other: _____

20. **Other methods I use to relieve or lessen my pain:** (Check all that apply)

- ☐ Acupuncture
- ☐ Aromatherapy
- ☐ Bio-feedback
- ☐ Breathing exercises
- ☐ Cold compress
- ☐ Warm Compress
- ☐ Distraction
- ☐ Guided imagery or hypnosis
- ☐ Massage
- ☐ Music
- ☐ Relaxation technique: _____
- ☐ Transcutaneous Electrical Nerve Stimulation (TENS) Unit
- ☐ Walking
- ☐ Other: _____