UCI HEALTHSYSTEM
AMBULATORY SELF-REPORTING
PAIN TOOL

PATIENT IDENTIFICATION

Name: __________________________ Date: __________________________

Place a mark on the line below that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10
No Pain Mild Moderate Severe Worst Possible Pain

PAIN SCALE

2. Where is the pain? On the picture below, mark the places where you feel pain.

RIGHT LEFT

LEFT RIGHT

3. What does the pain feel like?

☐ Pressure ☐ Burning ☐ Dull
☐ Aching ☐ Sharp ☐ Radiating
☐ Throbbing ☐ Shooting
☐ Cramping ☐ Tingling

4. Does the pain make it harder for you to:

☐ Walk ☐ Enjoy life
☐ Sleep ☐ Eat
☐ Sit ☐ Be active
☐ Work ☐ Be with family or friends

5. When is the pain worse? (check all that apply)

☐ In the morning ☐ With activity
☐ During the night
☐ I can’t predict when it will get worse
☐ Before my next dose of medicine

6. What other problems are you having?

☐ Constipation ☐ Fatigue/Tired easily
☐ Dry Mouth ☐ Nausea or vomiting
☐ Other __________________________

7. How is your pain controlled best?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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