Cancer Pain Assessment Form

Patient Name

Date

Medical Record Number

Pain Details

Location of Pain

Description of Pain

Onset of Pain

Pain Intensity (0 = No Pain, 10 = Worst Imaginable)

Duration & Frequency

Type of Pain

Factors That Increase Pain

Factors That Relieve Pain

Current Medications & Management

Medications Taken for Pain

Effectiveness of Pain Control Measures

Side Effects Experienced

Impact of Pain

How Pain Affects Daily Life

Comments or Additional Observations