## **Chronic Pain Assessment Form**

Patient Name
Date of Birth
Assessment Date
Assessment Date
Location of Pain
Duration of Pain
Type of Pain
<u> </u>
Pain Intensity (0 - No pain, 10 - Worst possible pain)
Factors that Aggravate Pain
Factors that Relieve Pain
Factors that Relieve Pain
Current Pain Medications & Dosages
Outrent Fair Wedications & Dosages
Impact on Daily Activities
Describe how pain affects daily activities
Additional Notes