Chronic Pain Evaluation Form

Patient Information

Full Name

Age

Gender

Date

Pain Description

Location(s) of Pain

Duration of Pain (e.g., months/years)

Frequency (e.g., constant, intermittent)

Pain Type (select all that apply)

- [ ] Sharp
- [ ] Dull
- [ ] Throbbing
- [ ] Burning
- [ ] Aching
- [ ] Other

Pain Intensity

Average Pain Level (0 = no pain, 10 = worst pain)

What makes the pain worse?

What makes the pain better?

Current Treatments

List any medications, therapies, or treatments you are using

Are they effective?

- Yes
- No
- Partially

Impact on Daily Life

Briefly describe how chronic pain affects your daily activities, sleep, and mood

Additional Information

Anything else you would like to mention?