

GOVERNMENT OF MEGHALAYA HEALTH AND FAMILY WELFARE DEPARTMENT

PAIN ASSESSMENT FORM

Name of the patient.....

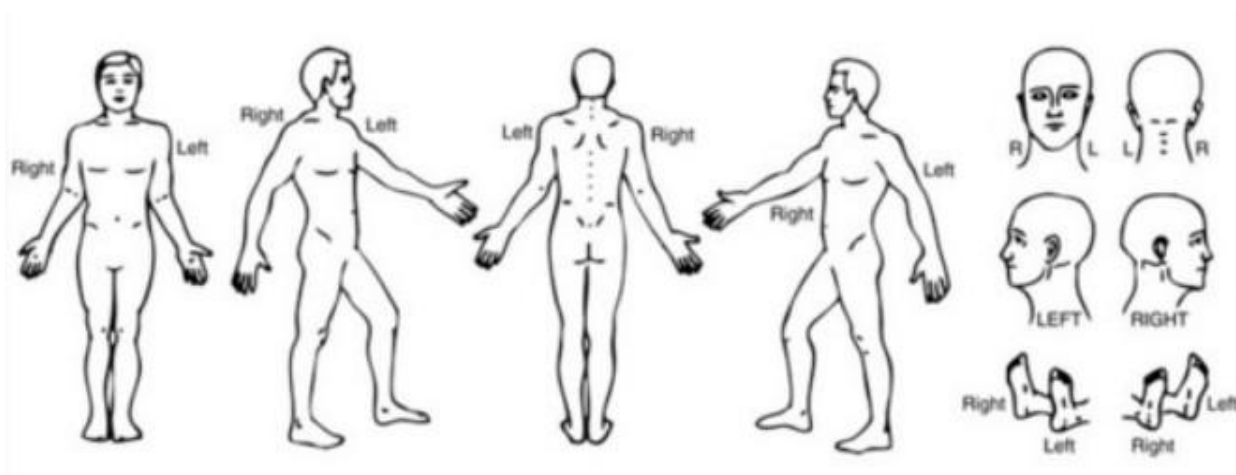
Age.....Gender.....Patient ID.....

Date and Time of Assessment.....

Pain Description

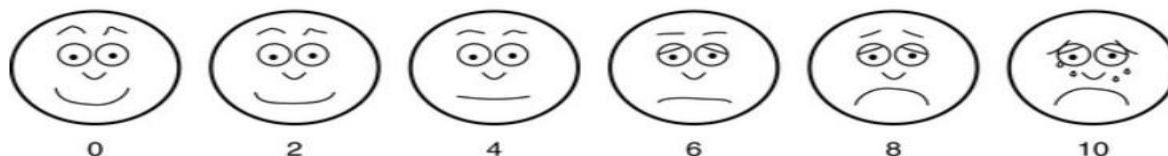
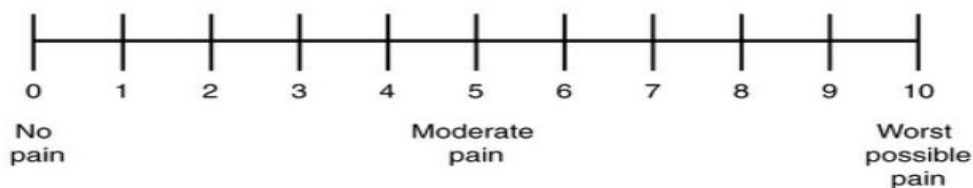
1. Onset and Duration of Pain.....

2. Location of Pain



(Mark X on pain areas & O on numbness areas)

Pain Visual Analog Scale



3. Pain Intensity (0-10)

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4. Quality of pain

Burning pain Dull aching pain Sharp pain Stabbing pain

Throbbing pain Shooting pain Numbing pain

Others specify

5. Functional Impact

i. Activities Affected (e.g., Walking, Sleeping)

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ii. Level of Interference (e.g., Mild, Moderate, Severe)

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iii. Associated Symptoms (Nausea, Vomiting, Sweating, Anxiety)

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iv. Aggravating activity (e.g., movement, stress, eating)

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v. Alleviating activity (rest, medication, cold/heat therapy)

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vi. Pain pattern (e.g., worse at night, periodic flare-ups)

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6. Non-Pharmacological intervention

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7. Medical Advice

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(Doctor's Signature)