

Interventional Pain Management
Clinic Walter Reed National Military
Medical Center

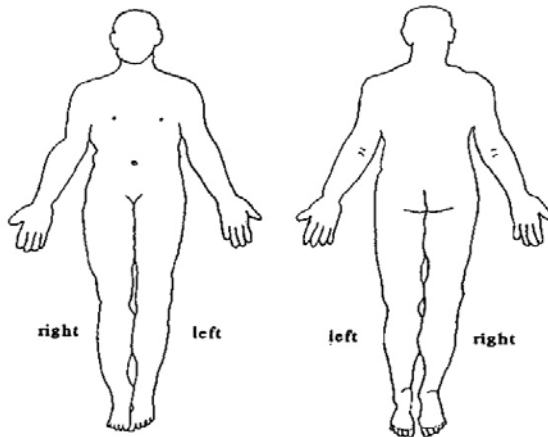
Follow-up Pain Assessment Tool

Name: _____	Date: _____
Sponsor SSN # _____	Age: _____
DOD # _____	
Referring Physician: _____	Primary Physician: _____

Have you fallen in the last 6 months? Y/N Were you injured in the fall? Y/N

Please mark the location of your current pain on the diagram below.

Vitals	
Temp	_____
Pulse	_____
Respirations	_____
Blood Pressure	_____
SpO ₂	_____
Height	_____
Weight	_____
Alcohol use Y/N	_____
Tobacco use Y/N	_____



Have you been deployed since September 11th 2001?
Y/N _____

Could the reason for your visit today in some way be related to your deployment?
Y/N _____

My pain affects my: (Mark all that apply)

<input type="checkbox"/> Ability to work	<input type="checkbox"/> Recreational Activities
<input type="checkbox"/> Hrs. you work per day: _____	<input type="checkbox"/> Relationship with family
<input type="checkbox"/> Ability to Sleep	<input type="checkbox"/> Relationship with friends
<input type="checkbox"/> Hrs. of sleep per night: _____	<input type="checkbox"/> Concentration
<input type="checkbox"/> Interrupted	Emotions: I am frequently: <input type="checkbox"/> Angry
<input type="checkbox"/> Uninterrupted	<input type="checkbox"/> Tearful
<input type="checkbox"/> Use sleep medication	<input type="checkbox"/> Sad
	<input type="checkbox"/> Suicidal

Do you have an active plan if suicidal? Y/N _____

Since my last visit my pain has:

Improved
 Stayed the same
 Worsened

The treatment or medication I received at my last visit:

Helped my pain
 Did not change my pain
 Worsened my pain

Since I have been treated in the pain clinic, overall I am doing:

Better
 The same
 Worse

Pain Severity

Today:

No Pain											
0	1	2	3	4	5	6	7	8	9	10	

Average Day:

0	1	2	3	4	5	6	7	8	9	10
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Worst in the last 2 weeks:

0	1	2	3	4	5	6	7	8	9	10
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Best in the last 2 weeks:

0	1	2	3	4	5	6	7	8	9	10
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Energy level the past week: (0=No Energy and 10=Feel full of energy)

0	1	2	3	4	5	6	7	8	9	10
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