UCI HEALTHSYSTEM
AMBULATORY SELF-REPORTING PAIN TOOL

PATIENT IDENTIFICATION

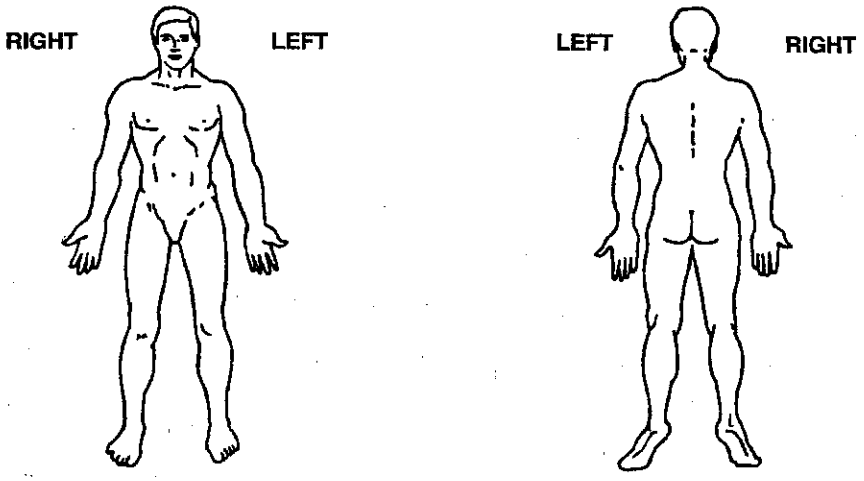
Name: _____ Date: _____

Place a mark on the line below that best describes your pain.

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild			Moderate			Severe		Worst Possible Pain

PAIN SCALE

2. Where is the pain? On the picture below, mark the places where you feel pain.



3. What does the pain feel like?

- ☐ Pressure
- ☐ Aching
- ☐ Throbbing
- ☐ Cramping
- ☐ Burning
- ☐ Sharp
- ☐ Shooting
- ☐ Tingling
- ☐ Dull
- ☐ Radiating

4. Does the pain make it harder for you to:

- ☐ Walk
- ☐ Sleep
- ☐ Sit
- ☐ Work
- ☐ Enjoy life
- ☐ Eat
- ☐ Be active
- ☐ Be with family or friends

5. When is the pain worse? (check all that apply)

- ☐ In the morning
- ☐ With activity
- ☐ During the night
- ☐ I can't predict when it will get worse
- ☐ Before my next dose of medicine

6. What other problems are you having?

- ☐ Constipation
- ☐ Dry Mouth
- ☐ Fatigue/Tire easily
- ☐ Nausea or vomiting
- ☐ Other _____

7. How is your pain controlled best? _____

_____

_____

_____

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