Patient Comfort Assessment Guide

Name: _____ Date: _____

1. Where is your pain? _____

2. Circle the words that describe your pain.

aching	sharp	penetrating
throbbing	tender	nagging
shooting	burning	numb
stabbing	exhausting	miserable
gnawing	tiring	unbearable

Circle One occasional continuous

What time of day is your pain the worst? Circle one.

morning afternoon evening nighttime

3. Rate your pain by circling the number that best describes your pain at its worst in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

4. Rate your pain by circling the number that best describes your pain at its least in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

5. Rate your pain by circling the number that best describes your pain on average in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

6. Rate your pain by circling the number that best describes your pain right now.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

7. What makes your pain better? _____

8. What makes your pain worse? _____

9. What treatments or medicines are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide(s) you.

a) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete Relief
Treatment or Medicine (include dose) Relief

b) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete Relief
Treatment or Medicine (include dose) Relief

c) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete Relief
Treatment or Medicine (include dose) Relief

d) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete Relief
Treatment or Medicine (include dose) Relief

Pain Disability Index

Name: _____ **Date** _____

Instructions: The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain on your life, not just when the pain is at its worst.

For each category, please circle the number which describes the levels of disability you typically experience. A score of 0 means no disability at all and a score of 10 means that all the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

1. **Family/home responsibilities.** Activities related to the home or family, including chores and duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

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

2. **Recreation.** Hobbies, sports and similar leisure time activities.

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

3. **Social activity.** Participation with friends and acquaintances other than family members, including parties, theater, concerts, dining out, and other social functions.

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

4. **Occupation.** Activities that are a part of or directly related to one's job, including nonpaying jobs such as that of a homemaker or volunteer work.

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

5. **Sexual activity.** This category refers to the frequency and quality of one's sex life. **(OPTIONAL)**

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

6. **Self-care.** Activities of daily maintenance and independent daily living (taking a shower, driving, getting dressed, etc.)

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

7. **Life-support activities.** Basic life-support behaviors such as eating, sleeping, and breathing.

   No disability 0 1 2 3 4 5 6 7 8 9 10 Total Disabilty

Name_____

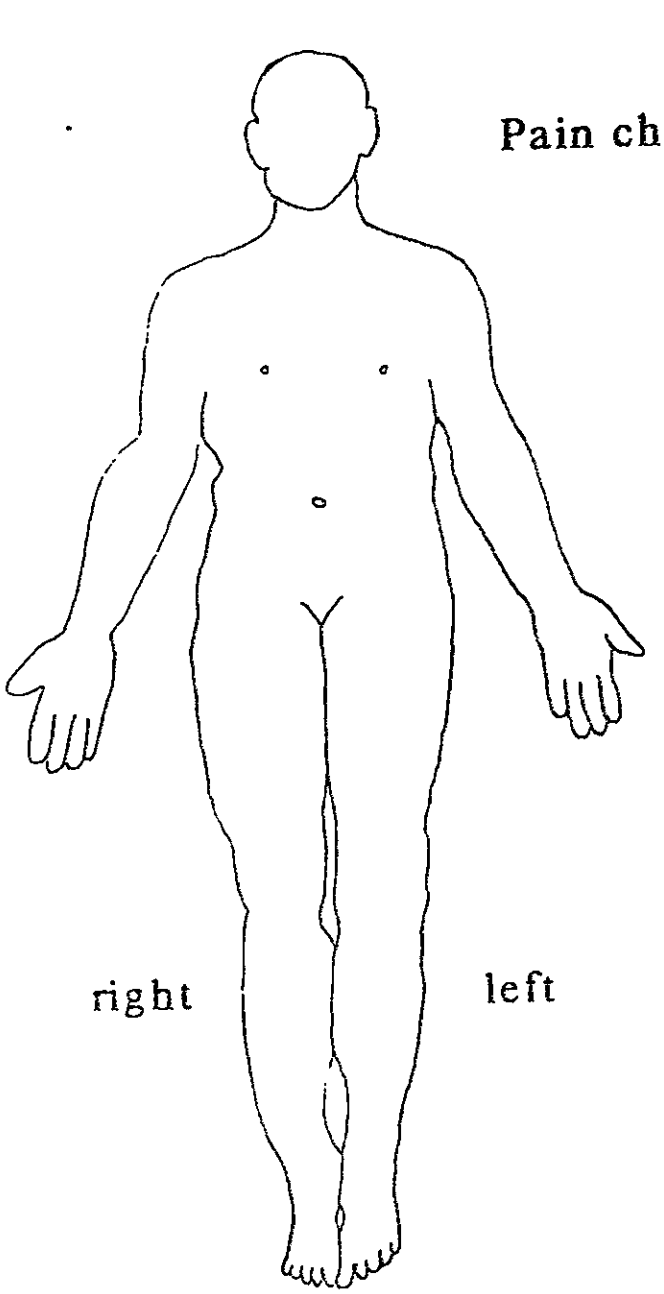
File_____

Date_____

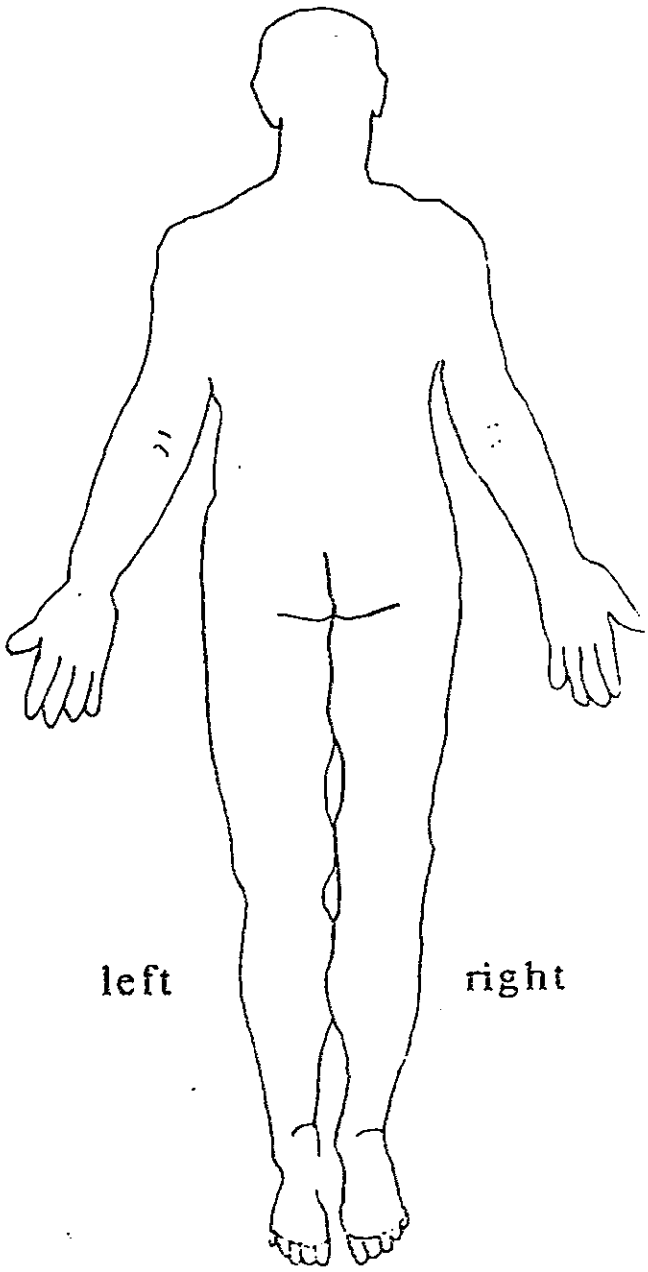
Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols.
Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////

Pain chart



right left



left right

Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP®-R)

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	✓ ○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	✓ ○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

 The SOAPP®-R was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU.org

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	o	o	o	o	o
14. How often have others told you that you had a bad temper?	o	o	o	o	o
15. How often have you felt consumed by the need to get pain medication?	o	o	o	o	o
16. How often have you run out of pain medication early?	o	o	o	o	o
17. How often have others kept you from getting what you deserve?	o	o	o	o	o
18. How often, in your lifetime, have you had legal problems or been arrested?	o	o	o	o	o
19. How often have you attended an AA or NA meeting?	o	o	o	o	o
20. How often have you been in an argument that was so out of control that someone got hurt?	o	o	o	o	o
21. How often have you been sexually abused?	o	o	o	o	o
22. How often have others suggested that you have a drug or alcohol problem?	o	o	o	o	o
23. How often have you had to borrow pain medications from your family or friends?	o	o	o	o	o
24. How often have you been treated for an alcohol or drug problem?	o	o	o	o	o

Please include any additional information you wish about the above answers.
Thank you.

ORT ASSESSSMNET

Dear Patient:

Please complete the following questionnaire as best as possible. It should take no more than 5 minutes of your time. This questionnaire assists us in making the most appropriate treatment plan for you. Please circle YES or NO for the following questions.

DO YOU HAVE A FAMILY HISTORY OF SUBSTANCE ABUSE?

Alcohol	YES NO
Illegal drugs	YES NO
Prescription drugs	YES NO

DO YOU HAVE A PERSONAL HISTORY OF SUBSTANCE ABUSE?

Alcohol	YES NO
Illegal drugs	YES NO
Prescription drugs	YES NO

DID THE SUBSTANCE ABUSE OCCUR BETWEEN THE AGES OF 16 TO 45? YES NO

DO YOU HAVE A HISTORY OF PREADOLESCENT SEXUAL ABUSE ? YES NO

DO YOU HAVE OR EVER BEEN TREATED FOR:

ATTENTION DEFICIT DISORDER	YES NO
OBSESSIVE-COMPULSIVE DISORDER	YES NO
BIPOLAR	YES NO
SCHIZOPHRENIA	YES NO
DEPRESSION	YES NO

Joseph T. Hayes M.D.
1970 North Broad St.
Lansdale, PA. 19446