PAIN ASSESSMENT TOOL

Check ☑ only the boxes are applicable

Patient's Name:	
Date:	
Do you believe that you know the origin of your pain?	Yes ☐ No If yes, please specify:
What seems to trigger it?	☐ Stress ☐ Position ☐ Certain Activities ☐ Other, please specify:
What relieves it?	☐ Medications ☐ Massage ☐ Heat/Cold ☐ Changing Position ☐ Being Active ☐ Resting ☐ Other, please specify:
What aggravates it?	☐ Movement ☐ Bending ☐ Lying Down ☐ Walking ☐Standing ☐ Other, please specify:
What does it feel like?	☐ Sharp ☐ Dull ☐ Stabbing ☐ Burning ☐ Crushing ☐ Throbbing ☐ Nauseating ☐ Shooting ☐ Twisting ☐Stretching ☐ Other, please specify:
Where is the pain located?	☐ Head ☐Neck ☐ Upper Back ☐Lower Back ☐ Chest ☐ Abdomen ☐ Upper Arm ☐ Shoulder ☐ Elbow ☐ Forearm ☐ Wrist ☐Hand ☐ Leg ☐ Hip ☐ Gluteal Region ☐ Thigh ☐ Knee ☐ Ankle ☐ Foot ☐ Right side ☐ Left side ☐ Both sides
Does the pain radiate?	☐Yes ☐ No If yes, please specify where:
How severe is the pain?	☐ Slight ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe ☐ The Most Intense Pain Imaginable
Does it interfere with activities of daily living?	☐ Physical functioning/General Activity ☐ Sleep patterns ☐ Mood ☐ Appetite ☐ Ability to concentrate ☐ Family relationships ☐ Social relationships ☐ OutsideWork ☐ Home/Housework ☐ Enjoyment of life ☐ Overall functioning
When do you usually experience it?	☐ Early morning ☐ Daytime ☐ Night
What are you currently doing to release your pain?	☐ Over the counter Pain Killers ☐ Prescribed Pain Killers ☐ Health/Nutritional/Dietary Supplement/s ☐ Other forms/s of therapy Please, provide information regarding your current analgesic regime.
Are you currently using Cannabis to alleviate your pain?	☐ Yes ☐ No
If yes, please specify:	☐ Prescribed Cannabis ☐ Non prescribed Cannabis Type: ☐ Fresh Marijuana ☐ Dried Marijuana ☐ Cannabis Oil ☐ Other, please specify: Daily Amount: ☐ ___g/d ☐ ___joints/d THC Percentage: ☐ <9%THC ☐ Other, please specify: ___ Length of Period Taken: ☐___Day/s ☐___Week/s ☐___Month/s ☐___Year/s Frequency Taken: ☐ Daily ☐ Weekly ☐ Monthly ☐ If other, please specify: Method and form of Administration: ☐Inhalation: ☐ Smoking (Involves burning the flowers and inhaling the released active components of the plant) ☐ Vaporizing (Involves heating the plant and inhaling the released active components of the plant) ☐ Oral: ☐ Edibles ☐ Tinctures ☐ Capsules ☐ Oils ☐ Sublingual: ☐ Dissolvable strips ☐ Sublingual sprays (Sativex) ☐ Medicated lozenges ☐ Tinctures ☐ Topical: ☐ Lotions ☐ Salves ☐ Bath salts ☐ Oils applied to the skin ☐ Other, please specify:
What is the current analgesic regime side effect(s)	☐ Nausea ☐ Vomiting ☐ Heartburn ☐ Upset Stomach ☐ Diarrhea ☐ Constipation ☐ Dry Mouth ☐ Abdominal Pain ☐ Rash ☐ Itching ☐ Hives ☐ Swelling of the lip and tongue ☐ Headache ☐ Memory impairment ☐ Confusion ☐ Hallucinations ☐ Dizziness ☐ Sedation ☐ Delirium ☐ Sweating ☐ Cold flashes ☐ Fatigue ☐ Insomnia ☐ Unexplained weight loss ☐ Seizures ☐ Slow heart beats ☐ Rapid heart beats ☐ Orthostatic Hypotension ☐ High Blood Pressure ☐ Urinary retention ☐ Involuntary leg movements ☐ Sharp bone and muscle pains ☐ Extreme agitation or irritability ☐ Increasing hostility ☐ Feelings of paranoia ☐ Unsteady movements and/or mannerisms ☐ Involuntary gestures, movements or tics ☐ Rapid, involuntary eyes movement ☐ Poor judgment and decision-making ☐ Other, please specify:
What are your goals regarding your analgesic regime that you would like to achieve during this visit?	☐ Discontinue ☐ Taper off present analgesic therapy ☐ Adjust dose of present analgesic therapy ☐ Add Cannabis to my present analgesic therapy ☐ Switch present analgesic/s to Cannabis ☐ Adjust my current prescribed Cannabis dosage ☐ Continue present Cannabis regime
What would you like to improve or you have improved using Cannabis therapy?	☐ Physical functioning/General Activity ☐ Sleep patterns ☐ Mood ☐ Appetite ☐ Ability to concentrate ☐ Family relationships ☐ Social relationships ☐ OutsideWork ☐ Home/Housework ☐ Enjoyment of life ☐ Overall functioning
	_____Patient's Initials