

Do you have a new pain?	YES	NO
Do you have pain that is not well controlled?	YES	NO
Do you have side effects that are not well controlled?	YES	NO

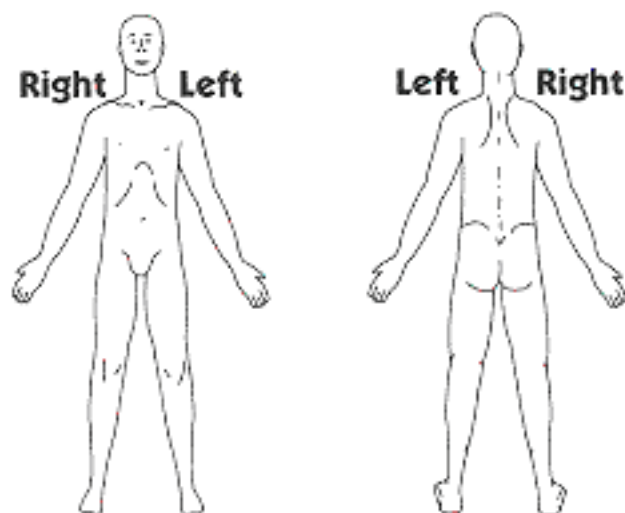
If you answered YES to any of these questions, please answer the questions below and call your doctor. Bring this page with you to your next doctor's appointment.



1. On the **Pain Scale** above, please mark a "W" to show how strong your pain is at its **worst** in the last 24 hours.

2. Next, please mark a "U" to show how strong your pain is at its **usual** level in the last 24 hours.

3. On the picture, shade the areas where you feel pain. Put an "X" on the area that hurts the most.



4. Check the statements that describe your pain:

- I am in pain all of the time.
- My pain comes and goes with:
 - time of day time since I took medicine
 - activity I can't predict it

5. Check the activities that the pain interferes with:

- Walking Sitting or lying down
- Working Sexual activity
- Eating Taking care of yourself
- Mood Enjoyment of life
- Sleep Relations with other people

6. Check the words that describe your pain:

- Pressure Shooting Burning
- Aching Stabbing Numb
- Throbbing Tingling Sharp

7. Check what you have tried for pain relief:

- Medicine Heat or Cold Rest
- Massage Activity Imagery
- Breathing Distraction

8. Check the words that describe how you are feeling:

- Hopeful Tense Irritable
- Cheerful Discouraged Confused
- Worried Blue No feelings
- Life is not worth living

9. Check the side effects you are having that are not well controlled:

- Dry mouth Sleepiness Nausea
- Constipation Vomiting Fatigue
- Other Symptoms _____