PainTracker™

University of Washington

Below is a list of locations of pain. In the first column, please indicate one or more areas where you have felt pain over the past week. In the second column, please indicate the ONE location of your most severe pain:

LOCATION	**ANY PAIN?** (√ ALL THAT APPLY)	**WORST PAIN?** (√ ONE ONLY)
Head		
Neck		
Chest		
Stomach		
Back		
Arm		
Hand		
Buttocks		
Genital/Urinary		
Leg		
Knee		
Foot		

Please rate your pain by filling in the circle of the one number that best describes your pain on the **average** in the last week?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

No Pain — Pain as bad as you can imagine

Fill in the circle of the one number that describes how, during the past week, **pain has interfered** with your:

General activity

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Does not interfere — Completely interferes

Enjoyment of life

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Does not interfere — Completely interferes

Falling asleep

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Does not interfere — Completely interferes

Staying asleep

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Does not interfere — Completely interferes

Chronic pain may limit activities that are very important to you (e.g., caring for children, walking, working). We hope your pain treatment will make it easier for you to do these important activities. **Please list one important activity that is difficult for you to perform** so that we can monitor it during your pain treatment.

Activity (describe): _____

How would you rate the **difficulty** you have had **doing this activity** over the past week? Can do with…

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
No difficulty										Extreme difficulty

Over the past 2 weeks, have you been bothered by these problems?

	Not at all	Several days	More days than not	Nearly every day
	0	1	2	3
Feeling nervous, anxious, or on edge	○	○	○	○
Not being able to stop or control worrying	○	○	○	○
Feeling down, depressed, or hopeless	○	○	○	○
Little interest or pleasure in doing things	○	○	○	○

Are you having any **side effects** from any of the medications you take for pain? ○ Yes ○ No

If yes, what is the most bothersome side effect? _____

Please circle the number that best shows the **severity of the most bothersome side effect**:

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
None										Severe

In the past month, how many "**bad days**" have you had where you **needed to take more pain** medication than your doctor is currently prescribing?

○	○	○	○
None	1 - 2	3 – 5	> 5

Please fill in the circle of the one number that best shows how **satisfied** you are with the **results of your pain treatment**:

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Extremely Dissatisfied										Extremely Satisfied

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