State of Franklin HEALTHCARE ASSOCIATES
Your Health, Our Focus

PAIN ASSESSMENT

Are you currently having pain? ( ) YES ( ) NO If yes, describe:

_____

_____

How long have you had this pain?

_____

What eases this pain?

_____

What causes or increases the pain?

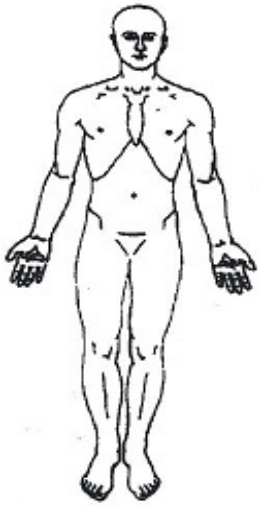
_____

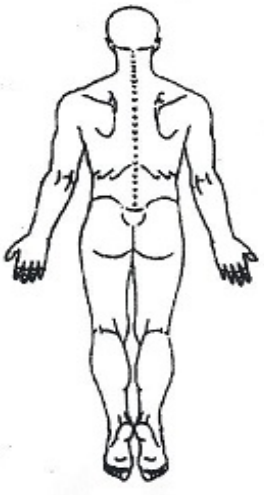
Rate your pain on a scale of 1 to 10, with 1 being no pain and 10 the most severe pain. Please use an X.

{_____}

1 2 3 4 5 6 7 8 9 10

Mark these drawings according to where you hurt.





Advance Directive Form? Yes ( ) No ( )

Living Will Form? Yes ( ) No ( )

(Blank forms are available in our waiting room)