PAIN PREVENTION
REHABILITATION CENTER

MANISH SUTHAR, MD
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Name: _____ **Age:** _____

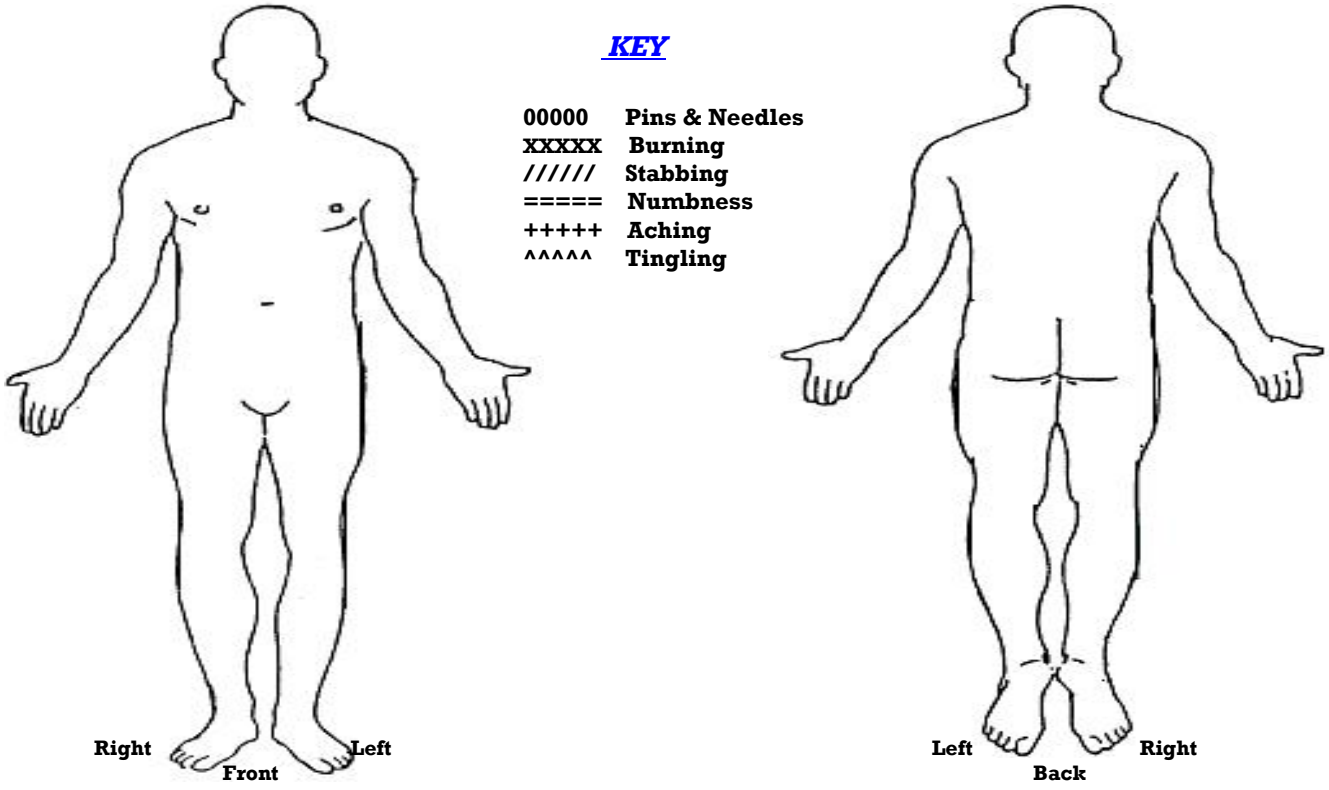
Average PAIN Over the Past Week:

No Pain		Low			Moderate			Intense		Unbearable
0	1	2	3	4	5	6	7	8	9	10

How has Pain affected your DAILY ACTIVITIES Over the Past Week:

No Affect		Low			Moderate			Intense		Not Able
0	1	2	3	4	5	6	7	8	9	10

Functional Problems due to Pain:_____



Do you understand your pain medication agreement?	□ NO	□ YES
Do you store your medications safely (lock safe)?	□ NO	□ YES
Do you know how to dispose of excess medications?	□ NO	□ YES
Do you ever cut, crush or chew your medications?	□ NO	□ YES
Do you share your prescriptions medications?	□ NO	□ YES
Do you suffer from constipation?	□ NO	□ YES