

CLIENT PAIN ANALYSIS (McGill Pain Scale)

Client Name	Date	Time
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From the following list tick any boxes that describe the pain you are experiencing (☑)

- | | | | | |
|---|---|--|--|--|
| 1. <input type="checkbox"/> Flickering
<input type="checkbox"/> Quivering
<input type="checkbox"/> Pulsing
<input type="checkbox"/> Throbbing
<input type="checkbox"/> Beating
<input type="checkbox"/> Pounding
2. <input type="checkbox"/> Jumping
<input type="checkbox"/> Flashing
<input type="checkbox"/> Shooting
3. <input type="checkbox"/> Pricking
<input type="checkbox"/> Boring
<input type="checkbox"/> Drilling
<input type="checkbox"/> Stabbing
4. <input type="checkbox"/> Sharp
<input type="checkbox"/> Cutting
<input type="checkbox"/> Lacerating | 5. <input type="checkbox"/> Pinching
<input type="checkbox"/> Pressing
<input type="checkbox"/> Chaffing
<input type="checkbox"/> Cramping
<input type="checkbox"/> Crushing
6. <input type="checkbox"/> Tugging
<input type="checkbox"/> Pulling
<input type="checkbox"/> Wrenching
7. <input type="checkbox"/> Hot
<input type="checkbox"/> Burning
<input type="checkbox"/> Scalding
<input type="checkbox"/> Searing
8. <input type="checkbox"/> Tingling
<input type="checkbox"/> Itchy
<input type="checkbox"/> Smarting
<input type="checkbox"/> Stinging | 9. <input type="checkbox"/> Dull
<input type="checkbox"/> Sore
<input type="checkbox"/> Hurting
<input type="checkbox"/> Aching
<input type="checkbox"/> Heavy
10. <input type="checkbox"/> Tender
<input type="checkbox"/> Taut
<input type="checkbox"/> Rasping
<input type="checkbox"/> Splitting
11. <input type="checkbox"/> Tiring
<input type="checkbox"/> Exhausting
12. <input type="checkbox"/> Sickening
<input type="checkbox"/> Suffocating
13. <input type="checkbox"/> Fearful
<input type="checkbox"/> Frightful
<input type="checkbox"/> Terrifying | 14. <input type="checkbox"/> Punishing
<input type="checkbox"/> Gruelling
<input type="checkbox"/> Cruel
<input type="checkbox"/> Vicious
<input type="checkbox"/> Killing
15. <input type="checkbox"/> Wretched
<input type="checkbox"/> Blinding
16. <input type="checkbox"/> Annoying
<input type="checkbox"/> Troublesome
<input type="checkbox"/> Miserable
<input type="checkbox"/> Intense
<input type="checkbox"/> Unbearable
17. <input type="checkbox"/> Spreading
<input type="checkbox"/> Raging
<input type="checkbox"/> Penetrating
<input type="checkbox"/> Focusing | 18. <input type="checkbox"/> Cool
<input type="checkbox"/> Cold
<input type="checkbox"/> Freezing
19. <input type="checkbox"/> Tight
<input type="checkbox"/> Numb
<input type="checkbox"/> Drawing
<input type="checkbox"/> Squeezing
<input type="checkbox"/> Tearing
20. <input type="checkbox"/> Nagging
<input type="checkbox"/> Nauseating
<input type="checkbox"/> Agonising
<input type="checkbox"/> Torturing
<input type="checkbox"/> 0 - No Pain
<input type="checkbox"/> 1 - Mild
<input type="checkbox"/> 2 - Discomfort
<input type="checkbox"/> 3 - Distressing
<input type="checkbox"/> 4 - Horrible
<input type="checkbox"/> Excruciating |
|---|---|--|--|--|

Frequency/Duration of pain (☑)

- Brief
 Momentary
 Transient
 Rhythmic
 Periodic
 Intermittent
 Continuous
 Steady
 Constant

Pain worse when (activity/position/time of day etc)

Pain better when (activity/position/stance/.time of day etc)

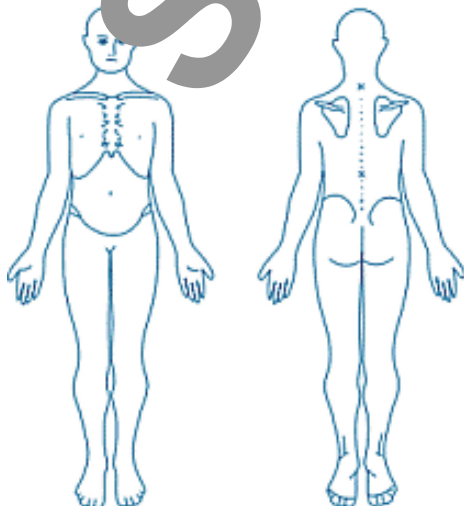
Hours of pain over last 24 hours

Pain Killers used during last 24 hours

Severity of Pain

Using the pain scale below, please estimate the amount of pain you have had over the past 24 hours—

No pain ●—————● Unbearable agony



Using the symbols listed please indicate location/s of pain

- Numbness ●●●
- Pulsating/Throbbing ~~~
- Burning ×××
- Stabbing ▲▲▲
- Pins & Needles ●●●
- Radiating/Travelling ⇐↑↓⇒

Other