

CLIENT PAIN ANALYSIS (McGill Pain Scale)

Client Name Date Time

From the following list tick any boxes that describe the pain you are experiencing (✓)

- | | | | | |
|--|--|---|---|--|
| <p>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</p> <p>2. <input type="checkbox"/> Jumping
<input type="checkbox"/> Flashing
<input type="checkbox"/> Shooting</p> <p>3. <input type="checkbox"/> Pricking
<input type="checkbox"/> Boring
<input type="checkbox"/> Drilling
<input type="checkbox"/> Stabbing</p> <p>4. <input type="checkbox"/> Sharp
<input type="checkbox"/> Cutting
<input type="checkbox"/> Lacerating</p> | <p>5. <input type="checkbox"/> Pinching
<input type="checkbox"/> Pressing
<input type="checkbox"/> Chaffing
<input type="checkbox"/> Cramping
<input type="checkbox"/> Crushing</p> <p>6. <input type="checkbox"/> Tugging
<input type="checkbox"/> Pulling
<input type="checkbox"/> Wrenching</p> <p>7. <input type="checkbox"/> Hot
<input type="checkbox"/> Burning
<input type="checkbox"/> Scalding
<input type="checkbox"/> Searing</p> <p>8. <input type="checkbox"/> Tingling
<input type="checkbox"/> Itchy
<input type="checkbox"/> Smarting
<input type="checkbox"/> Stinging</p> | <p>9. <input type="checkbox"/> Dull
<input type="checkbox"/> Sore
<input type="checkbox"/> Hurting
<input type="checkbox"/> Aching
<input type="checkbox"/> Heavy</p> <p>10. <input type="checkbox"/> Tender
<input type="checkbox"/> Taut
<input type="checkbox"/> Rasping
<input type="checkbox"/> Splitting</p> <p>11. <input type="checkbox"/> Tiring
<input type="checkbox"/> Exhausting</p> <p>12. <input type="checkbox"/> Sickening
<input type="checkbox"/> Suffocating</p> <p>13. <input type="checkbox"/> Fearful
<input type="checkbox"/> Frightful
<input type="checkbox"/> Terrifying</p> | <p>14. <input type="checkbox"/> Punishing
<input type="checkbox"/> Gruelling
<input type="checkbox"/> Cruel
<input type="checkbox"/> Vicious
<input type="checkbox"/> Killing</p> <p>15. <input type="checkbox"/> Wretched
<input type="checkbox"/> Blinding</p> <p>16. <input type="checkbox"/> Annoying
<input type="checkbox"/> Troublesome
<input type="checkbox"/> Miserable
<input type="checkbox"/> Intense
<input type="checkbox"/> Unbearable</p> <p>17. <input type="checkbox"/> Spreading
<input type="checkbox"/> Raging
<input type="checkbox"/> Penetrating
<input type="checkbox"/> Focusing</p> | <p>18. <input type="checkbox"/> Cool
<input type="checkbox"/> Cold
<input type="checkbox"/> Freezing</p> <p>19. <input type="checkbox"/> Tight
<input type="checkbox"/> Numb
<input type="checkbox"/> Drawing
<input type="checkbox"/> Squeezing
<input type="checkbox"/> Tearing</p> <p>20. <input type="checkbox"/> Nagging
<input type="checkbox"/> Nauseating
<input type="checkbox"/> Agonising
<input type="checkbox"/> Torturing</p> <p><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</p> |
|--|--|---|---|--|

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)

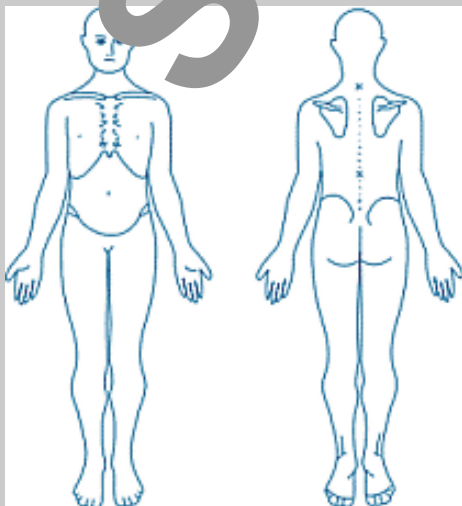
Hours of pain over last 24 hours

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