SURGERY CENTER OF SOUTH CENTRAL KANSAS

1708 EAST 23RD – HUTCHINSON, KS 67502 – 620-664-5252

To help you understand your pain . . .

REPORT ALL CHEST OR POSSIBLE HEART PAIN TO YOUR HEALTH CARE PROVIDER OR FAMILY IMMEDIATELY

0-1

NO PAIN to "just barely" noticeable. It may not be possible to get to this level. If you do, then GREAT!

2-3

Pain is present, but you may have to stop and think about it to really tell it is there and not gone. You seem just fairly comfortable . . . let's keep it there!

4-5

You now notice your pain perhaps at rest or during activity. It may interfere with your activities. THE LEVEL AT WHICH IT IS A GOOD IDEA TO START TO DO SOMETHING TOWARD RELIEF IS 3-4! Speak now . . . Avoid the RUSH!

6-7

Your pain is distracting you, but you may be able to focus on something else rather than the pain for a short period of time. You may be "gritting your teeth" to carry out activities.

8-9

Your pain may be severe enough that it makes you stop in the middle of an activity, or not be able to complete it at all. It is difficult to think of anything else when your pain at this level. You may be uncomfortable even during rest or quiet times.

10

Your pain is now the worst you can imagine, but it is not necessary to be "crying" to be at a level 10 in pain!

I FEEL PAIN IN MY . . . (such as)

Head . . . Neck . . . Back . . . Hip . . . Chest . . . Arm . . . Hand . . . Finger . . .
Leg . . . Foot . . . Toe . . ., etc.

Please consider these questions that will help us to treat your pain:

PAIN HISTORY (Reason For Visit)

When did your pain start?

Is your pain a result of an accident or fall?

Location of pain?

Does pain radiate? (if so, where to?)

Any numbness, tingling, weakness? (if so, where?)

How would you describe your pain? (burning, stabbing, aching, cramping are a few examples but you may use other descriptive terms)

Is your pain constant or intermittent?

Indicate any prior treatment or therapies you have received to relieve your pain (list when, where and for how long your received them)

Physical Therapy Chiropractic Treatment Accupuncture Massage

How would you rate your pain, using a number scale from "0" (no pain), up to "10" (worst possible pain). Refer above to help you decide.

Assistive Devices: Braces Crutches Wheelchair Other: _____

***This form is for you to keep – you do not need to return it to our office.**