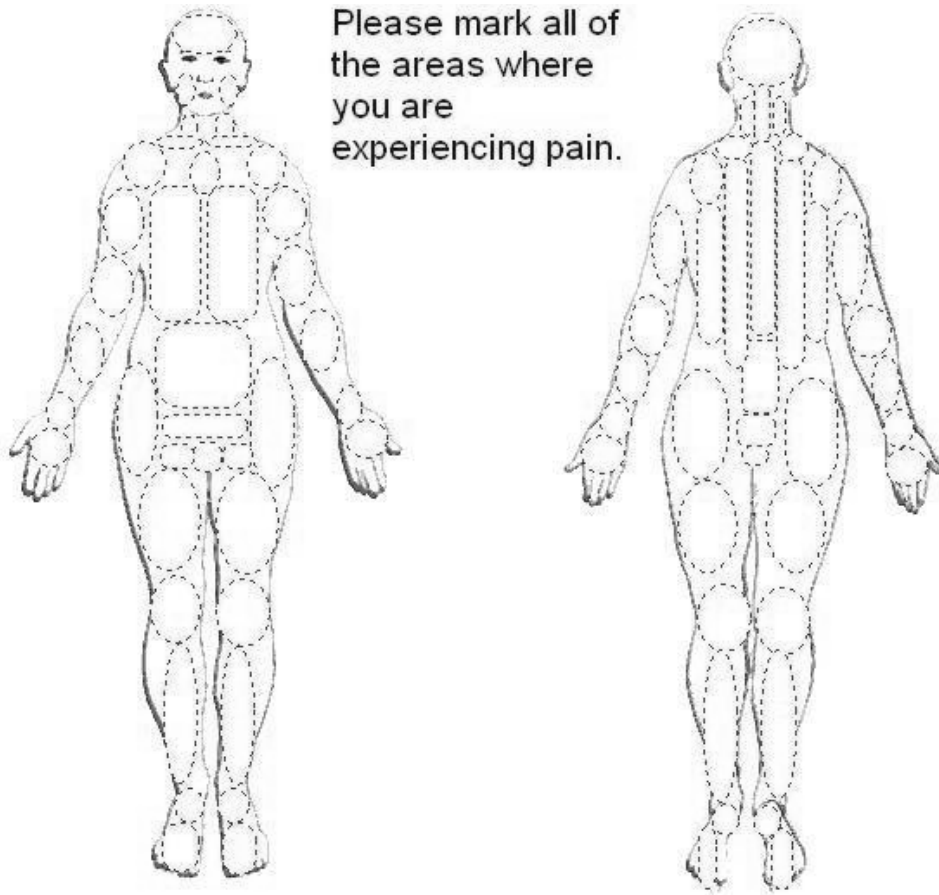


PQRI Measure 131, Pain Assessment

Patient Identification Number	Survey Date	MM	DD	YYYY
		<input type="text"/>	<input type="text"/>	<input type="text"/>



Please mark all of the areas where you are experiencing pain.

Please select all that describes your pain and circle the intensity for each one selected:

Description of Pain	Intensity		
	Mild	Moderate	Severe
Throbbing			
Shooting			
Stabbing			
Sharp			
Cramping			
Gnawing			
Hot / Burning			
Aching			
Heavy			
Tender			
Splitting			
Tiring / Exhausting			
Sickening			
Fearful			
Punishing / Cruel			