Lifeforce Proactive
HEALTH CENTRE

Patient Stress Assessment

Patient Name: ______________________ **Date:** ______________ **Case #:** ____________

1. **Please rate your pain** by **circling** the one number that best describes **your pain** at its **WORST** in the past week.

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										PAIN AS BAD AS YOU CAN IMAGINE

2. **Please rate your pain** by **circling** the one number that best describes **your pain** at its **LEAST** in the past week.

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										PAIN AS BAD AS YOU CAN IMAGINE

3. **Please rate your pain** by **circling** the one number that best describes **your pain** on the **AVERAGE**.

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										PAIN AS BAD AS YOU CAN IMAGINE

4. **Please rate your pain** by **circling** the one number that tells how much **pain** you have **RIGHT NOW**.

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										PAIN AS BAD AS YOU CAN IMAGINE

5. Circle the one number that describes how during the past week, **PAIN** HAS **INTERFERED** with **your:**

A. General activity

0	1	2	3	4	5	6	7	8	9	10
DOES NOT INTERFERE										COMPLETELY INTERFERES

B. Mood

0	1	2	3	4	5	6	7	8	9	10
DOES NOT INTERFERE										COMPLETELY INTERFERES

C. Walking ability

0	1	2	3	4	5	6	7	8	9	10
DOES NOT INTERFERE										COMPLETELY INTERFERES

D. Normal work (includes work both outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
DOES NOT INTERFERE										COMPLETELY INTERFERES

E. Relationships with other people

0	1	2	3	4	5	6	7	8	9	10
DOES NOT INTERFERE										COMPLETELY INTERFERES

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
DOES NOT INTERFERE										COMPLETELY INTERFERES

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
DOES NOT INTERFERE										COMPLETELY INTERFERES

6. What treatments or medications are you receiving for your pain? ____________

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