Patient ID: ____ Patient Name: _

OUCH!
Pain Sensitivity Test

Patient Consent

I understand that this test is to compare my opinion of pain tolerance with what I experience when a small lead weight is dropped upon my fingernail and the body part to be evaluated. I may stop the test at any time just by saying I do not wish to finish.

I understand my participation in this test will help the doctor evaluate my problem.

I understand that the information collected for this study will be confidential and kept separate from my medical records. There will be no personal identification or information published that would compromise my privacy.

I am willing to participate in this test to evaluate my sensitivity to pain.

_____
Date

_____
Patient signature

_____
Witness

_____
Examiner

1. AGE: _____ years

2. GENDER:
- ☐ male
- ☐ female

3. RACE OR GENETIC HERITAGE:
- ☐ African (black)
- ☐ Asian or Pacific Islander
- ☐ Caucasian (white)
- ☐ Hispanic
- ☐ Native American Indian
- ☐ other: _____

4. DOMINANT HAND:
- ☐ right
- ☐ left
- ☐ truly ambidextrous

5. EMPLOYMENT:
- ☐ yes, I am presently employed
- ☐ no
- ☐ retired
- ☐ unemployed
- ☐ off on physical disability for _____
  % disability: _____
  reason for disability: _____

6. ARE YOUR INDEX FINGERS NORMAL?
- ☐ yes
- ☐ no If no, describe: _____

7. ARTIFICIAL NAILS?
- ☐ yes
- ☐ no

8. LONG NAILS?
- ☐ yes
- ☐ no

9. NAIL POLISH?
- ☐ yes
- ☐ no

10. DO YOU HAVE ANY BLEEDING TENDENCY?

☐ yes If yes, describe: _____

☐ no

---

11. DO YOU HAVE ANY PAIN ANYWHERE IN YOUR BODY NOW?

☐ yes **If yes, how much bodily pain do you have?**

☐ no (choose one answer)

☐ none

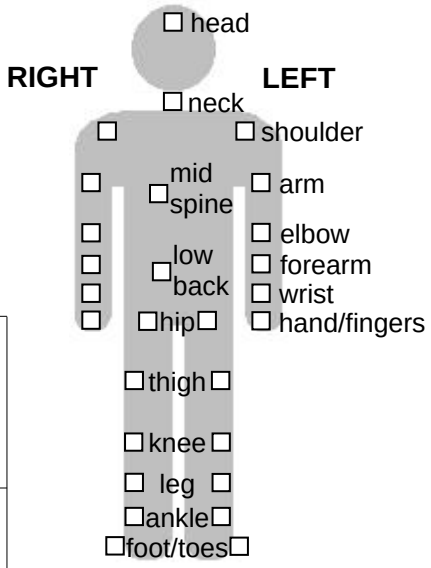
☐ very mild **If yes, where?**

☐ mild

☐ moderate

☐ severe

☐ very severe



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12. HAVE YOU TAKEN ANY MEDICATION THAT COULD AFFECT PAIN IN THE LAST 24 HOURS?

☐ yes

☐ no

---

13. WHAT HAS CAUSED YOU THE MOST PHYSICAL PAIN YOU EVER HAD?

(choose one answer)

Injury:

☐ laceration (cut)

☐ fracture (broken bone)

☐ dislocation (of joint)

☐ other injury: _____

☐ childbirth

☐ kidney stone

☐ surgery: _____

☐ other: _____

14. PATIENT'S RESPONSE TO QUESTION ESTIMATING THEIR PAIN TOLERANCE? (choose only one number)

	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	
(no pain tolerance)												(the most pain tolerance I can imagine anyone would have)

15. FINGER OUCH TESTING:

Finger tested: (Listed in order of preference. Use same finger on both hands.)

Right: ☐ index ☐ little ☐ ring ☐ middle ☐ thumb

Left: ☐ index ☐ little ☐ ring ☐ middle ☐ thumb

Level	**Right**	**Left**	
top	____	____	0 (no pain) – 10 (the most pain I can imagine anyone having)
5	____	____	
4	____	____	Perform tests on right side then left side.
3	____	____	Start with level 1 and move up.
2	____	____	Verify that ball does not land on cuticle, or beyond finger tip.
1	____	____	

Comments: _____

16. AFFECTED BODY PART OUCH TESTING:

Body part: ☐ hip ☐ knee ☐ ankle ☐ shoulder ☐ elbow ☐ wrist other: _____

Symptomatic:	**Right**	**Left**
	☐ yes	☐ yes
	☐ no	☐ no

Drop	**Right**	**Left**	
3 feet	____	____	0 (no pain) – 10 (the most pain I can imagine anyone having)
2 feet	____	____	Perform tests on asymptomatic side first, then the symptomatic side.
1 foot	____	____	Start with 1 foot and move up.

Comments: _____

17. PATIENT'S POST TEST RATING: ☐ I liked the test. ☐ I disliked the test.

Any suggestions? _____

18. THE FOLLOWING POST TEST WARNING WAS GIVEN: ☐ yes ☐ no

If your fingernail bleeds or gets black, please let us know, you might have a bleeding tendency.

19. EXAMINER'S ESTIMATION OF PATIENT'S PAIN TOLERANCE AFTER TESTING: (choose only one number)

	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	
(no pain tolerance)												(the most pain tolerance I can imagine anyone would have)

20. NOTES: