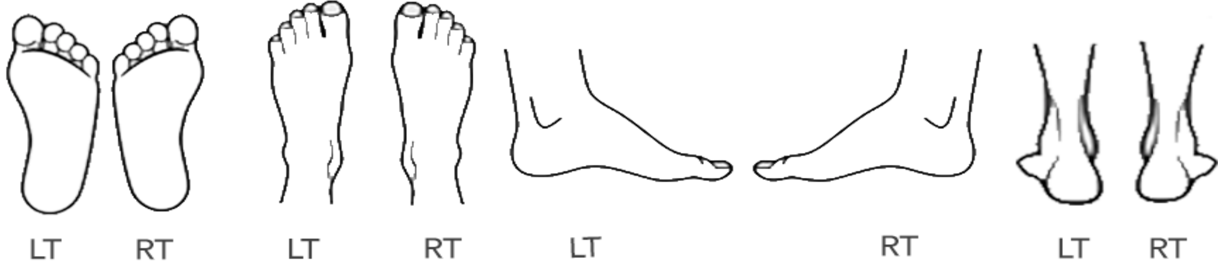
QDRIFT Communication Tool for Evaluation & Management of Pain

Patient Name: ____ Date of Birth: _____/_____/_____

Check all that apply

Primary Site(s) of Pain—Where is pain located?			
Nails Toes Interspace	Ball of Foot Arch	Heel Top Bottom	Lower Leg Ankle

Is this affecting you right now? Yes No



Quality of Pain—How does the pain feel?			
☐ Sharp ☐ Throbbing ☐ Stiff ☐ Burning	☐ Radiating ☐ Dull ☐ Sore ☐ Achy	☐ Itchy ☐ Pain on Palpation ☐ Changing	☐ Phantom Pain ☐ Cramping ☐ Unchanged
Duration—How long does the pain last?			
☐ Constant ☐ Intermittent	☐ Momentary ☐ Increasing	☐ Decreasing	☐ Unchanged
Region—Boundaries of the pain?			
☐ Expanding ☐ Contracting	☐ Limited ☐ Referred	☐ Multifocal	☐ Unchanged
Intensity—How strong is the pain?			
☐ Awareness ☐ Sensitive ☐ Discomfort ☐ Mild	☐ Moderate ☐ Tolerable ☐ Limit Activities	☐ Affecting Activities of Daily Living ☐ Avoid Activities ☐ Debilitating	☐ Cannot bare weight ☐ Unchanged ☐ Better ☐ Worse
Frequency—How often pain occurs?			
☐ Daily ☐ Nightly	☐ Constant ☐ Intermittent	☐ Increasing ☐ Decreasing	☐ Unchanged
Timing—When does the pain occur?			
☐ Morning ☐ After Activity	☐ After Exercise ☐ At night	☐ Acute ☐ Chronic	☐ After Surgery ☐ After Trauma

What makes it better/worse: ____

____

For Healthcare Team Member: Clinical Lens			
☐ Neuropathic ☐ Stoic ☐ Hypersensitive	☐ On Pain Medication ☐ Self-Medicating ☐ Non-Communicative	☐ Within Normal Limits ☐ Past Addictions ☐ Present Additions	☐ Other:

Patient Signature: ____ Date: _____/_____/_____

Copyright ©2023 By Segel J, Crawford S, and Kraus J. Free use for medical professionals without alteration.