

Name:

DOB:

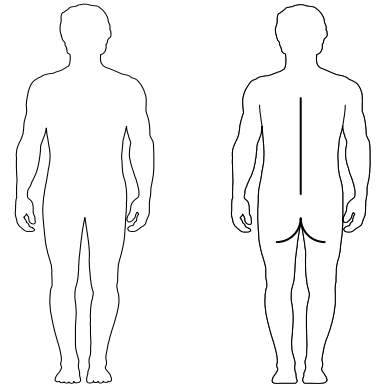
MR#:

Pain Questionnaire

1. Where is your pain? Write in words or use the picture to show where you have pain.

2. Circle the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable



3. Does your pain occur occasionally, frequently or is it constant? (Circle one)

Occasionally Frequently Constant

4. What time of day is your pain the worst? (Circle one)

Morning Afternoon Evening Nighttime

5. Rate your pain by circling the number that best describes your pain at its **worst** in the last month.

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

6. Rate your pain by circling the number that best describes your pain at its **least** in the last month.

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

7. Rate your pain by circling the number that best describes your pain on **average** in the last month.

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

8. Rate your pain by circling the number that best describes your pain **right now**.

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

Pain History Form continued on reverse...

9. What makes your pain **better**? _____

10. What makes your pain **worse**? _____

11. What treatment or medication are you receiving for your pain? If you are not receiving any treatment or medication, circle NONE.

None

12. Circle the one number that describes how, during the past week, pain has interfered with your:

a. General Activity Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

b. Mood Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

c. Normal Work Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

d. Sleep Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

e. Enjoyment of life Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

f. Ability to concentrate Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

g. Relationships with other people Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

Patient Signature _____

Date: ___/___/_____

Notes:

No action plan required.

Action plan required. See progress note.

Clinician Signature & Professional Designation _____ Date: ___/___/_____