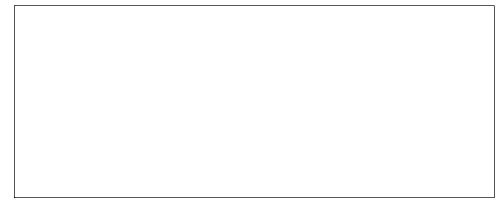
Howard County
Physical Therapy Sports Rehabilitation



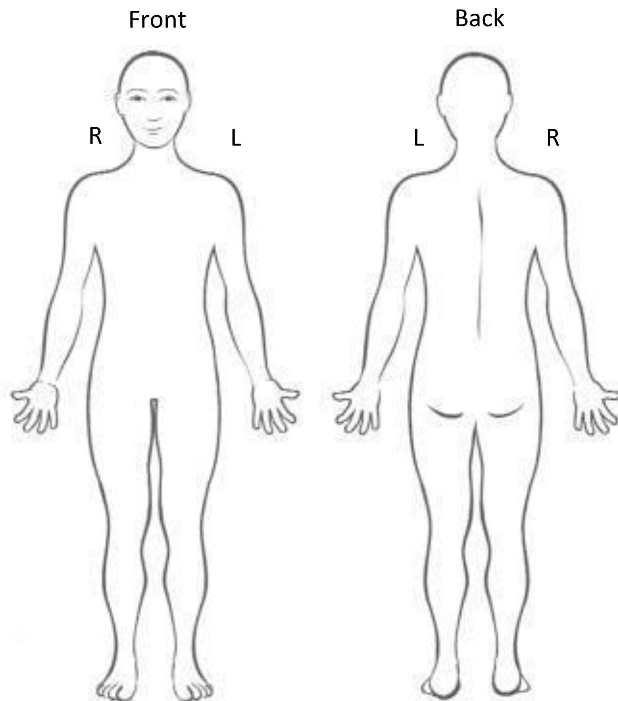
Pain Questionnaire/Assessment

1. What area are you seeking treatment for today? ____

2. Please rate your pain from 0 - 10, where 0 = no pain and 10 = the worst you can imagine (circle the number):

   Least Pain: 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain:** 0 1 2 3 4 5 6 7 8 9 10 **Today:** 0 1 2 3 4 5 6 7 8 9 10

3. Please place an X in the area(s) of pain.



4. Please place a check mark (√) in the Yes box if the word describes your pain and if the symptom is present, indicate with a check mark (√) if it is constant or occasional.

Aching	□ Yes	□ Constant	□ Occasional
Throbbing	□ Yes	□ Constant	□ Occasional
Shooting	□ Yes	□ Constant	□ Occasional
Dull	□ Yes	□ Constant	□ Occasional
Sharp	□ Yes	□ Constant	□ Occasional
Cramping	□ Yes	□ Constant	□ Occasional
Burning	□ Yes	□ Constant	□ Occasional
Numb	□ Yes	□ Constant	□ Occasional

Other word(s) to describe your pain: ____________________
____
____

5. During the past three (3) days, indicate what your pain has interfered with: Check (√) all that apply.
   □ Self-care ability □ Walking ability □ Work □ Sleep □ General Activity □ Mood □ Concentration
   □ Other: ____

6. Is **sitting** tolerance limited? □ Yes □ No Is **standing** tolerance limited? □ Yes □ No

7. How many minutes can you **walk**? _______ minutes How many minutes can you **stand**? _______ minutes

8. What positions or activities make your pain worse? (for example: bending, walking, turning, in the morning, after activity)

   ____

9. What kinds of things make your pain better? (for example: rest, heat, medicine)

   ____

Patient Signature: ______________________________ **Date**: ________________

The information on this form will be reviewed and discussed with the patient, and the information will be incorporated into the treatment goals and plan of care established in collaboration with the patient.

Revised 5/4/16 PT Reviewed: ____________