



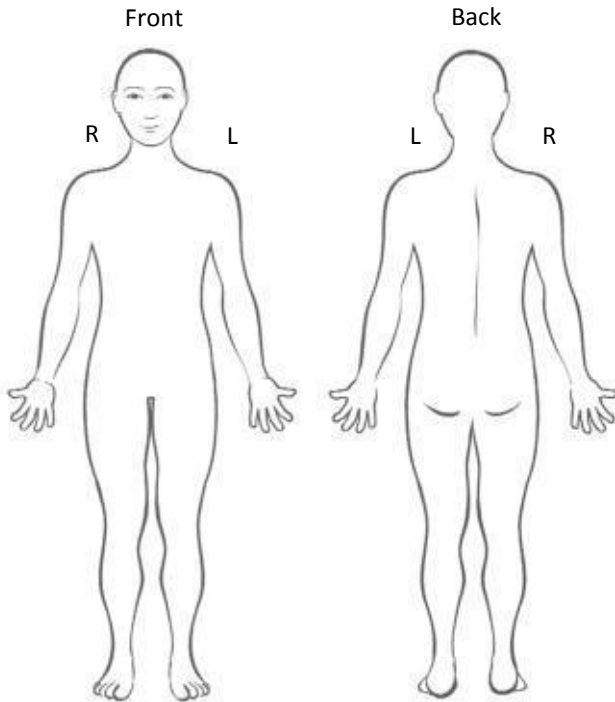
**Pain Questionnaire/Assessment**

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    | <input type="checkbox"/> Yes | <input type="checkbox"/> Constant | <input type="checkbox"/> Occasional |
| Throbbing | <input type="checkbox"/> Yes | <input type="checkbox"/> Constant | <input type="checkbox"/> Occasional |
| Shooting  | <input type="checkbox"/> Yes | <input type="checkbox"/> Constant | <input type="checkbox"/> Occasional |
| Dull      | <input type="checkbox"/> Yes | <input type="checkbox"/> Constant | <input type="checkbox"/> Occasional |
| Sharp     | <input type="checkbox"/> Yes | <input type="checkbox"/> Constant | <input type="checkbox"/> Occasional |
| Cramping  | <input type="checkbox"/> Yes | <input type="checkbox"/> Constant | <input type="checkbox"/> Occasional |
| Burning   | <input type="checkbox"/> Yes | <input type="checkbox"/> Constant | <input type="checkbox"/> Occasional |
| Numb      | <input type="checkbox"/> Yes | <input type="checkbox"/> Constant | <input type="checkbox"/> 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.