

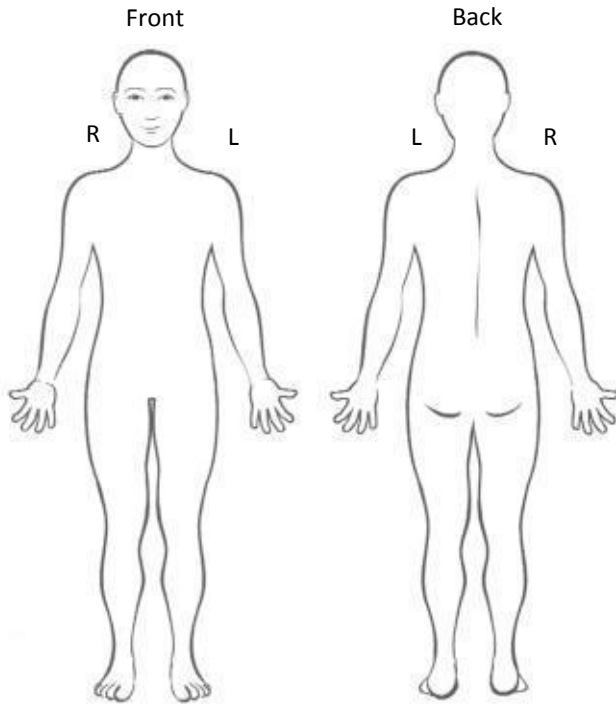
Pain Questionnaire/Assessment

Patient Name: _____

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: _____

(if patient is a minor parent/guardian must sign)

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.