Pain Questionnaire

Name: _______________________________ Date: ____________________

Age: ____  Sex: Male  Female  Dominant Hand: Right  Left  Diagnosis: ____________________________

1. Pain is difficult to describe. Circle the words that best describe your symptoms:
   Burning  Throbbing  Aching  Stabbing  Tingling  Twisting  Squeezing
   Cramping  Cutting  Shooting  Numbing  Vague  Stinging  Indescribable
   Pulling  Smarting  Pressure  Coldness  Dull  Other: ____________________________

   Level of symptoms: place a mark through the line to indicate the level of your pain, if zero is no pain and
   the end of the line is the most severe pain you can imagine having  .

2. Mark your average level of pain in the last month:

   | No Pain | Most Severe Pain |

3. Mark your worst level of pain in the last week:

   Right  | No Pain | Most Severe Pain |
   Left   | No Pain | Most Severe Pain |

4. Where is your pain? (Draw on diagram)

5. Mark on this scale how your pain has affected your quality of life:

   0%  Not at all  100%  A Large Amount

6. Mark on this scale how depressed you currently feel:

   0%  Not at all  100%  A Large Amount
7. Mark on this scale how frustrated you currently feel:

0% 100%
Not at all A Large Amount

8. Mark on this scale how angry you currently feel:

0% 100%
Not at all A Large Amount

9. Mark your average level of stress in the last month:

at home

0 10

at work

0 10

10. How well are you able to cope with that stress:

at home

Very Well Not at all

at work

Very Well Not at all

11. How did the pain that you are now experiencing occur?
   a. Sudden onset with accident or definable event
   b. Slow progressive onset
   c. Slow progressive onset with acute exacerbation without an accident or definable event
   d. A sudden onset without an accident or definable event

12. How many surgical procedures have you had in order to try to eliminate the cause of your pain?
   a. None or one
   b. Two surgical procedures
   c. Three or four surgical procedures
   d. Greater than four surgical procedures

13. Does movement have any effect on your pain?
   a. The pain is always worsened by use or movement
   b. The pain is usually worsened by use and movement
   c. The pain is not altered by use and movement
14. Does weather have any effect on your pain?
   a. The pain is usually worse with damp or cold weather.
   b. The pain is occasionally worse with damp or cold weather.
   c. Damp or cold weather has no effect on the pain.

15. Do you ever have trouble falling asleep or awaken from sleep?
   a. No - Proceed to Question 16       b. Yes - Proceed to 15A & 15B

15A. How often do you have trouble falling asleep?
   a. Trouble falling asleep every night due to pain
   b. Trouble falling asleep due to pain most nights of the week
   c. Occasionally having difficulty falling asleep due to pain
   d. No trouble falling asleep due to pain
   e. Trouble falling asleep which is not related to pain

15B. How often do you awaken from sleep?
   a. Awakened by pain every night
   b. Awakened from sleep by pain more than 3 times per week
   c. Not usually awakened from sleep by pain
   d. Restless sleep or early morning awakening with or without being able to return to sleep, both unrelated to pain

16. Has your pain affected your intimate personal relationships?
   a. No       b. Yes

17. Are you involved in any legal action regarding your physical complaint?
   a. No       b. Yes

18. Is this a Workers' Compensation case?
   a. No       b. Yes

19. Are you presently receiving or have you ever received psychiatric/psychological treatment?
   a. No       b. Presently receiving psychiatric treatment  c. Previous psychiatric treatment

20. Have you ever thought of suicide?
   a. No       b. Yes       c. Previous suicide attempts

21. Are you a victim of emotional abuse?
   a. No       b. Yes       c. No comment

22. Are you a victim of physical abuse?
   a. No       b. Yes       c. No comment

23. Are you a victim of sexual abuse?
   a. No       b. Yes       c. No comment
24. Are you presently a victim of abuse?
   a. No       b. Yes       c. No comment

25. Are you currently: (Check all that apply)
   Employed for wages ____ Yes     ____ No
   On medical leave ____ Yes       ____ No
   A homemaker ____ Yes           ____ No
   Self-employed ____ Yes         ____ No
   Student ____ Yes               ____ No
   Retired ____ Yes               ____ No
   Volunteer ____ Yes             ____ No
   None of the above ____ Yes     ____ No

26. If you are still working, do you?
   a. Work every day at the same pre-pain job.
   b. Work every day but the job is not the same as the pre-pain job with reduced responsibility or physical activity
   c. Work occasionally.

27. Are you able to do your household chores?
   a. Do same level of household activities without discomfort.
   b. Do same level of household chores with discomfort.
   c. Do a reduced amount of household chores.
   d. Most household chores are now performed by others.

28. What medications have you used in the past month?
   a. No medications
   b. List medications: ____________________________________________
      ____________________________________________
      ____________________________________________

29. If you had three wishes for anything in the world, what would you wish for?

   1. ___________________________________________________________
   2. ___________________________________________________________
   3. ___________________________________________________________

Modified by 12/20/12

From: