

Pain Questionnaire

Please rate your pain on a scale between 0-10. 0=no pain 10=severe pain-must go to the emergency room

In the following conditions (circle the number)

| | | | | | | | | | | | | |
|--------------|---------|---|---|---|---|---|---|---|---|---|----|----------------|
| Right now: | no pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | worst possible |
| At rest: | no pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | worst possible |
| With activit | no pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | worst possible |
| At night: | no pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | worst possible |
| In morning | no pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | worst possible |

Please check all that apply to your type of pain

- | | | |
|---|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Constant pain | <input type="checkbox"/> Sharp | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Comes and goes | <input type="checkbox"/> Dull | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Aches | <input type="checkbox"/> Stings | <input type="checkbox"/> Burns |
| <input type="checkbox"/> Throbs | <input type="checkbox"/> Shooting | |

What decreases your pain? _____

What increase your pain? _____

Mark these drawings according to where you hurt. If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram. Include all affected areas.

