Pain Questionnaire

Patient Name: _____ Date: _____

1. How old were you when your pain began? _____

2. Mark the areas on these diagrams below where you feel PAIN or any UNUSUAL FEELING.
Use the symbols below to mark areas of pain and discomfort if any. *Include all affected areas.*

Numbness
- - - - - - - -

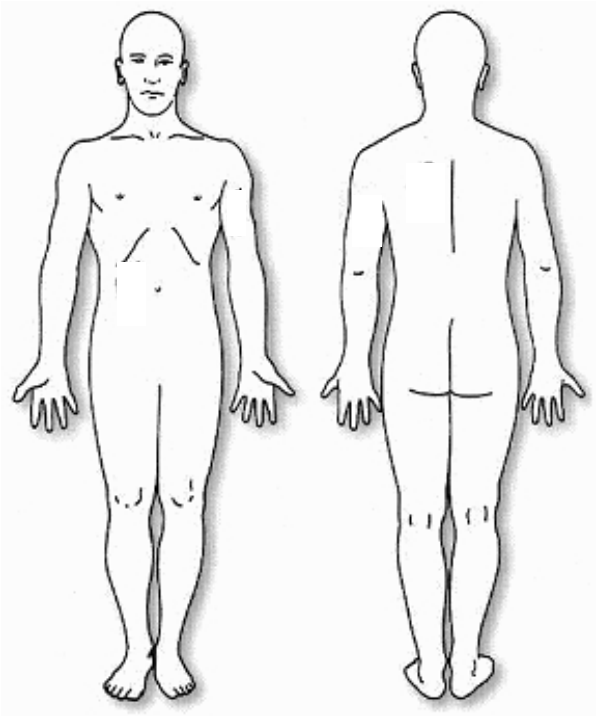
Pins & Needles
0 0 0 0 0 0

Burning
x x x x x x

Aching
*** * * * * * ***

Stabbing
/ / / / / / / /

Scars
S S S S



Neck-Shoulder-Arm Pain
Rate discomfort level you now feel

0 (no pain) 5 10 (severe pain)

Mid-Back Pain
Rate discomfort level you now feel

0 (no pain) 5 10 (severe pain)

Low-Back Pain
Rate discomfort level you now feel

0 (no pain) 5 10 (severe pain)

Leg-Knee-Foot Pain
Rate discomfort level you now feel

0 (no pain) 5 10 (severe pain)

3. Is your pain ever any of the following?
❑ Sharp ❑ Burning ❑ Aching ❑ Cramping ❑ Dull
❑ Moving ❑ Fixed ❑ Constant ❑ Intermittent ❑ Other:_____

4. Do the following lessen the pain?
❑ Pressure ❑ Cold ❑ Ice ❑ Heat ❑ Dampness ❑ Dryness ❑ AM ❑ PM
❑ Exercise ❑ Other:_____

5. Do the following worsen the pain?
❑ Pressure ❑ Cold ❑ Ice ❑ Heat ❑ Dampness ❑ Dryness ❑ AM ❑ PM
❑ Exercise ❑ Other:_____

6. List specific movements or activities that aggravate the pain: _____

7. Does this condition affect your sleep in any way? ❑ Yes ❑ No

Describe:_____

8. Which medications are you currently taking for pain?

Medication	Reason for Taking	Year Started	Dose
Example: Ibuprofen	pain	2008	20mg
1.			
2.			
3.			