

Pain Questionnaire

Name of Patient _____ Date of Birth _____

Today's Date _____ Physician's Name _____ Chart No. _____

1. How long have you had your pain?

2. What brought on your pain?

3. If you have back problems, what percent of your pain is -- (Total = 100%)
(R) Leg ___% (L) Leg ___% Back ___%

4. If you have neck problems, what percent of your pain is -- (Total = 100%)
(R) Arm ___% (L) Arm ___% Back ___%

5. What, if anything, makes the pain better?

6. What, if anything, makes the pain worse?

7. How long (or far) can you --
Sit _____ Stand _____ Walk _____

8. If you take medications, what are you taking, and how much?

9. Have you had any --
Numbness or tingling in your arms or legs?

Weakness in your arms or legs?

Change in your ability to control your bowel or bladder?

10. On a scale of 1 to 10, with 10 being the worst, your pain is --
1 2 3 4 5 6 7 8 9 10

11. Since its onset, your pain has --
_____ improved _____%
_____ worsened _____%
_____ stayed the same.

12. Have you had any treatment prescribed by another doctor for this condition? If so, please describe.

13. Mark these drawings using the symbols to best describe your pain --
Numbness ===== Aching + + + +
Pins & needles o o o o Stabbing // // //
Burning X X X X Cramping □ □ □ □
Location of worst pain * * * *

