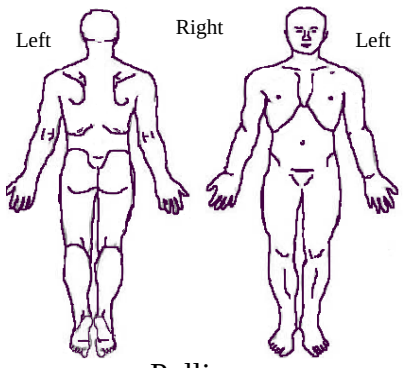
*Name:*_____ *Date:*_____

PAIN QUESTIONNAIRE

Where is your pain?_____

_____

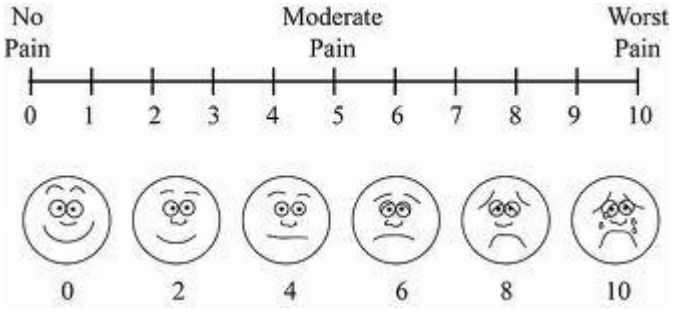
Mark an X where you are experiencing your pain.



Circle the words how you would describe your pain:

Dull	Throbbing	Shock-like	Pulling
Ache	Sore	Stabbing	Piercing
Sharp	Burning	Tender	_____
Shooting	Heaviness	Pressure	_____
Lacinating	Gnawing	Cramping	_____

Using the 0-10 scale (0=no pain 10=worst pain imaginable) , please circle the number for your current pain level (C) worst (W) and best (B) over the past week.



What medications/dosage have you taken for pain over the past week?

_____

_____

_____

How often does it hurt? □ Constant □Intermittent □AM □PM □Sometimes

What relieves your pain?
□Rest □Ice □Heat □Activity □Medication □_____

What aggravates your pain?
□Activity_____ □ Position_____□_____
□Cough □Standing □Sitting

What other problems are there because of the pain?
□Appetite Loss □Change in Activity □Difficulty Thinking □Irritable □Loss of Sleep
□Nausea/vomiting □_____