PAIN QUESTIONNAIRE

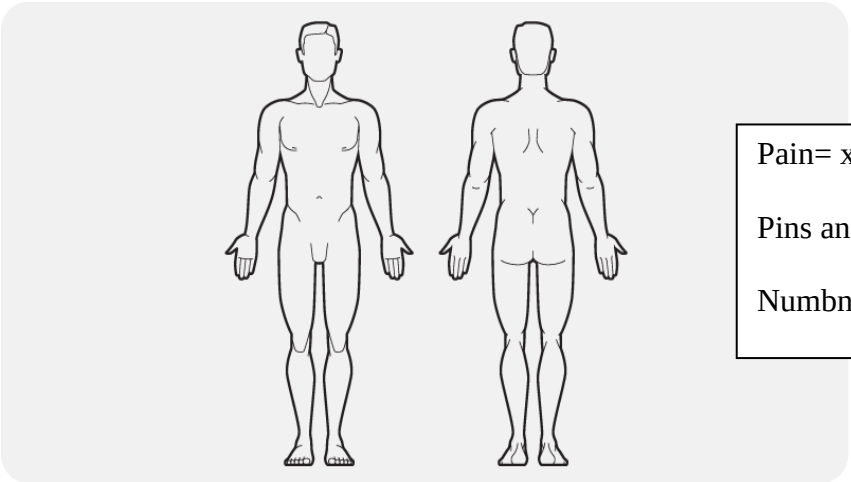
Name: _____ **Date**:_____

Indicate the quality of your symptoms (mark all that apply):

□ Constant □ Intermittent □ Dull □ Sharp □ Ache □ Other:_____

Is it worse in the: □ Morning □ Daytime □ Evening □ At Work □ Sleeping □ Other

Please indicate the type and location of your pain in the picture below:



Pain= xxxxxxxxxxx

Pins and Needles= ::::::::::::::::

Numbness= ///////////////

Rate your current pain by circling the corresponding number:

0= no pain 10= pain that would send you to the ER

0 1 2 3 4 5 6 7 8 9 10

At your best:_____ At your worst:_____

What makes your pain better? _____

What makes your pain worse? _____

Other comments:

_____

_____