ORTHOPEDIC EDGE physical therapy

PT INITIALS _____

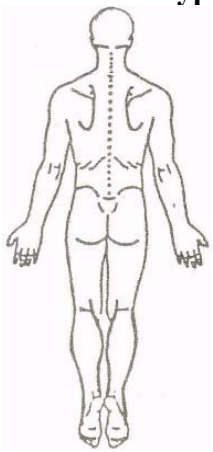
PAIN QUESTIONNAIRE

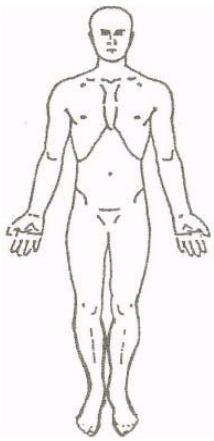
Name: _____ **Date:** _____

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 ☐ Other: _____

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





Pain= xxxxxxxxxxxxxxxxxx
Pins and Needles= ::::::::::::::::::::::::::::
Numbness= ////////////////////////////////

Rate your current pain by circling the corresponding number

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

0 1 2 3 4 5 6 7 8 9 10

At your best_____ **At your worst**_____

Provoking and Alleviating factors:
What makes your pain better? _____

What makes your pain worse? _____

What is your realistic pain goal? _____

Comments: _____

_____

PT comments: _____

_____

_____

☐ Discussed/re-established pain goal(s): _____