

Pain Questionnaire/Self Assessment

Section A (General information)

Initial Assessment Re-assessment

Date of last self assessment: _____

1. Date: _____ Time: ____:____

Referred by: _____

2. Name: _____ Home Phone: _____

3. Date of Birth: _____ 4. Sex: Male Female

Section B (Questions)

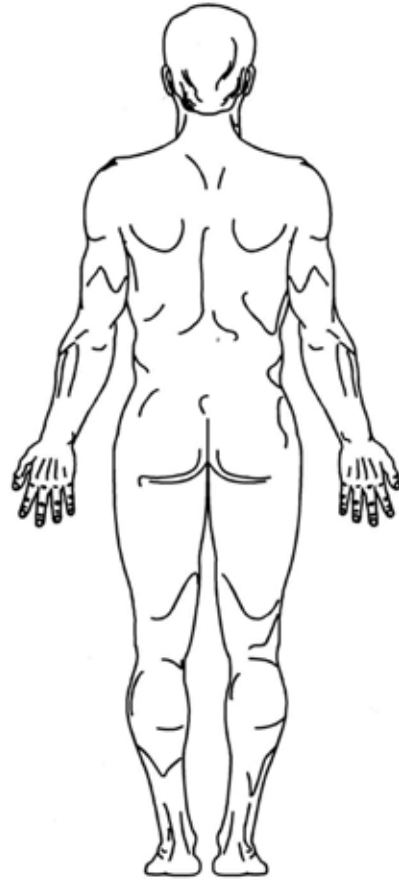
- Throughout our lives, most of us have had pain from time to time, such as minor headaches, sprains, and toothaches. Have you had pain other than these everyday kinds of pain today? Yes No
- On the diagrams below, circle the areas where you feel pain and/or any abnormal sensations (pins & needles, burning, numbness, etc.). Put an X on the areas that hurt the most.



Right



Left



See Other Side

Pain Questionnaire/Self Assessment

Section A (General information)

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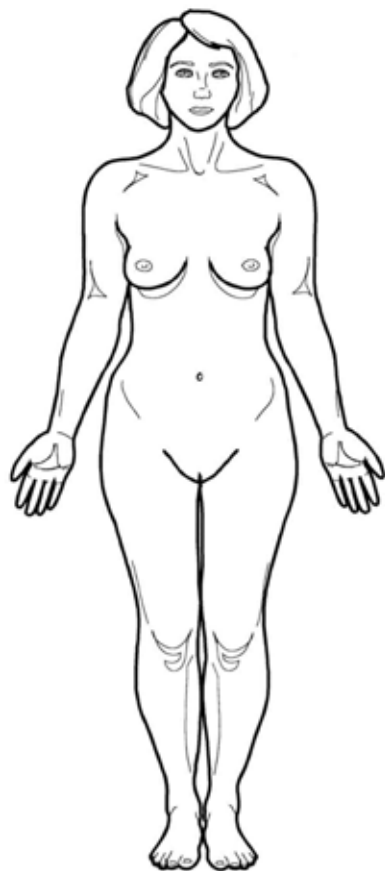
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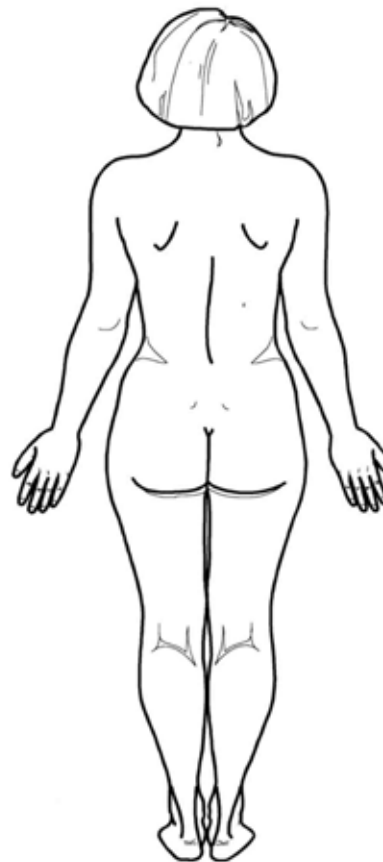
Section B (Questions)

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Right



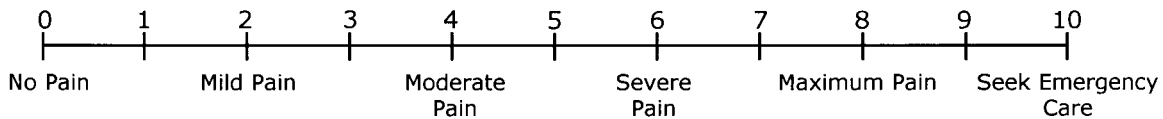
Left



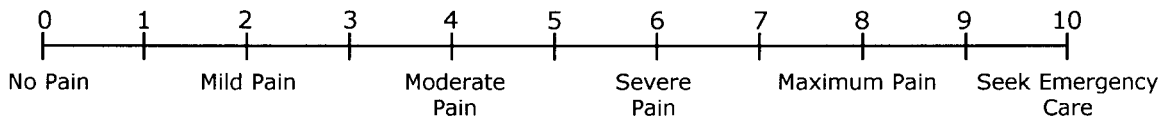
See Other Side

Section B (Questions)

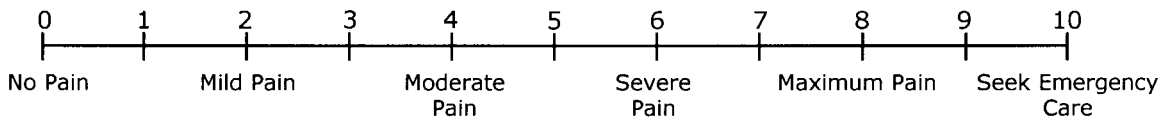
3. Please rate your pain by circling the one number that best describes your pain at its **worst** in the past 24 hours.



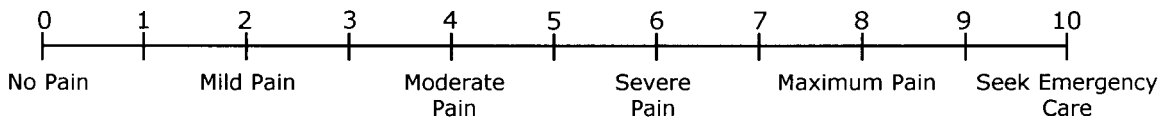
4. Please rate your pain by circling the one number that best describes your pain at its **least** in the past 24 hours.



5. Please rate your pain by circling the one number that best describes your pain on the **average**.

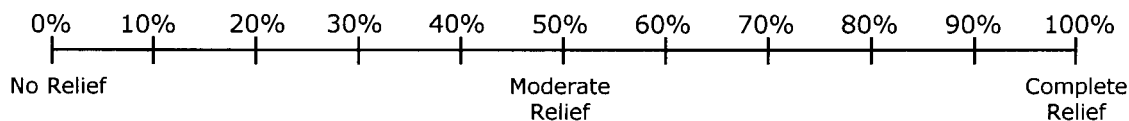


6. Please rate your pain by circling the one number that tells how much pain you are in **right now**.

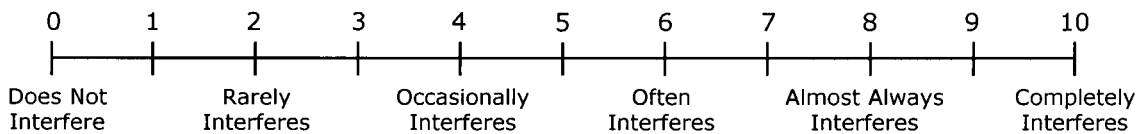
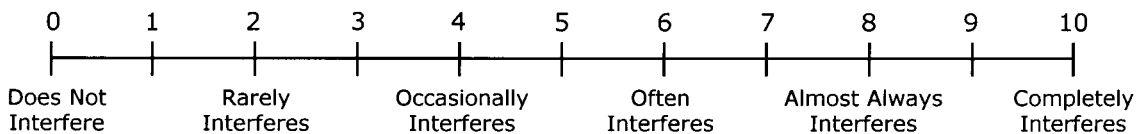


7. What treatments or medications are you receiving for your pain? _____

8. In the last 24 hours, how much pain **relief** has pain treatments or medications provided? Please circle the



9. Circle the one number that describes how, during the past 24 hours, **pain has interfered** with your:

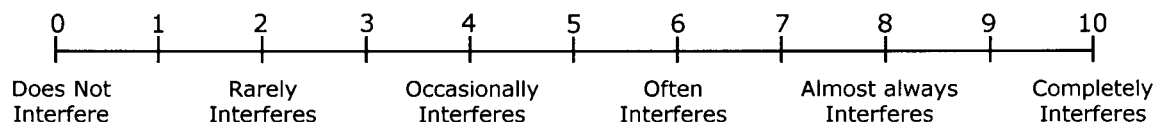
A. General Activity**B. Mood**

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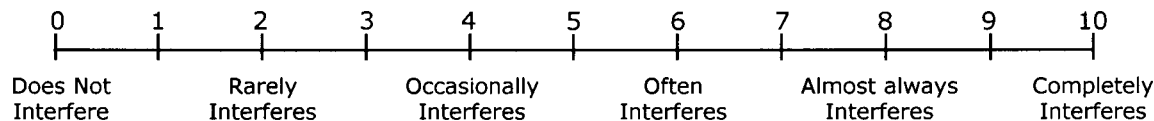
Section B (Questions)

9. Circle the one number that describes how, during the past 24 hours, **pain has interfered** with your:

C. Walking ability



D. Normal work (includes both work outside the home and housework)



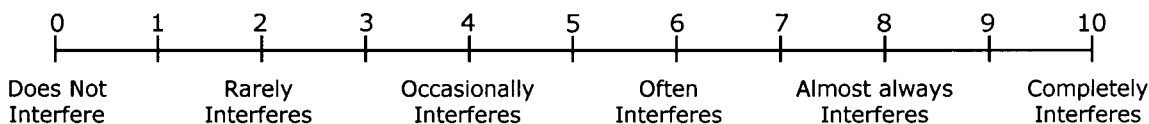
E. Relations with other people



F. Sleep



G. Enjoyment of life



10. How long have you been experiencing your pain at a significant level? _____

11. What do *you* believe to be the primary cause of your pain? _____

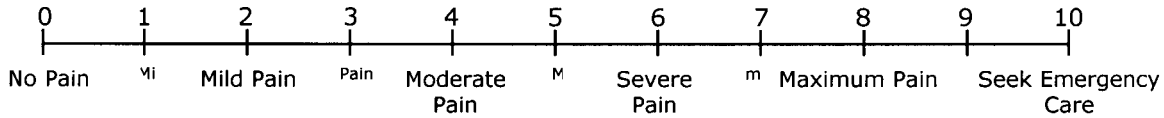
12. Circle the one number below that best describes how you feel about achieving significant lasting pain relief.



See Other Side

Section B (Questions)

13. Circle the one number below that best describes your **average** pain level for the **last 3 months**.



14. Can you attribute one event in your life that would be the most likely influence in the development of your pain?

No Yes : explain _____

15. What *times of the day* is your pain the **worst** on average? morning afternoon evening sleep time

16. What *times of the day* is your pain the **least** on average? morning afternoon evening sleep time

17. Is your pain less intense after you **rest**? No Yes : explain _____

18. Is your pain less intense after **activity**? No Yes : explain _____

19. Do any of the following **decrease** your pain? ice or cold gel pack moist heat Balms or liniments

20. Do any of the following **increase** your pain? ice or cold gel pack moist heat Balms or liniments

21. What in general **causes** or increases your pain? _____

22. What things have **you** done that makes your pain less intense? _____

23. Are there any **movements** (bending over, raising your arm, etc.) that are painful or *increases* your pain?

24. Are there any **movements** (bending over, raising your arm, etc.) that *lessens* your pain? _____

25. Are there any **movements** that you are *weak* in or can no longer perform? _____

26. Do you feel that your pain is effected by changes in weather? No Yes Sometimes

27. Do you feel that your pain is made worse by emotional stress? No Yes Sometimes

28. Do you believe that most people do not relate to your pain? No Yes Somewhat

29. Do you believe that you understand the causes of your pain, your symptoms and available treatments? No Yes Somewhat Comments: _____

30. Do you feel that you would like more knowledge about your "pain condition"? No Yes Somewhat

31. Do you feel that most of the health care practitioners involved in your care have satisfied your needs as a whole person with regard to your pain? No Yes Somewhat Comments: _____

◆ I affirm that I have answered all questions honestly. Signature: _____

◆ I affirm that I have explained and answered all questions honestly for this patient (section A, number 2.).

◆ Surrogate signature: _____