

Pain Questionnaire

Name: _____

Date: _____

Where is your pain? Please mark on the drawing the area where you feel your pain. Use the symbols that best describe your pain.

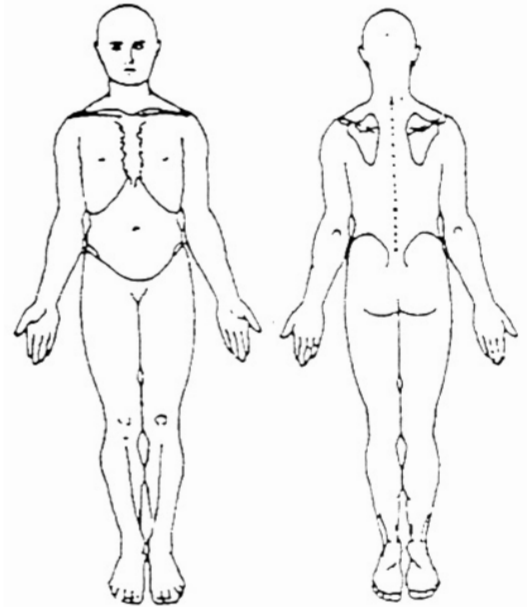
Dull Aching
NNNNNNN

Stabbing
/// /// ///

burning
XXXXXX

Pins and Needles
:.....:

Numbness
=====



Mark the positions which are painful:

Lying on back _____ Lying on stomach _____

Sidelying _____ Sitting _____ Getting Up _____

Walking _____ Stair Climbing _____

Are your symptoms;

Getting Worse _____ The Same _____ Improving _____

Does the pain keep you from work? Yes _____ No _____

How well do you sleep at night?
Fine _____ Moderate Difficulty _____ Only with Medication _____

What is the distance you can walk without pain?
Less than 200 yds _____ 200-500 yds _____ 1/2 mile _____ 1 mile _____ Don't Know _____

Is the pain worsened by cough or strain? Yes _____ No _____

Have you taken steroids such as Prednisone or Cortisone? Yes _____ No _____

Have you ever taken anticoagulants such as Heparin or Coumadin? Yes _____ No _____

Do you have any metal implants such as hip replacement, pins or plates, or a pacemaker? Yes ___ No ___

If you are having pain, rate the severity on a scale of 0-10, where 0 is no pain and 10 is the worst pain imaginable.

At Best: 0 1 2 3 4 5 6 7 8 9 10 (circle one number)
At Worst: 0 1 2 3 4 5 6 7 8 9 10 (circle one number)
At This Time: 0 1 2 3 4 5 6 7 8 9 10 (circle one number)