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THERAPY & WELLNESS

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PAIN QUESTIONNAIRE

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you don't understand a question, leave the area blank and your therapist will assist you. Thank you!

Body Chart:

Are you in PAIN? YES____ NO_____

WHERE:_____

Gradual onset of PAIN? YES____ NO_____

Constant PAIN? YES____ NO_____

PAIN worse at night? YES____ NO_____

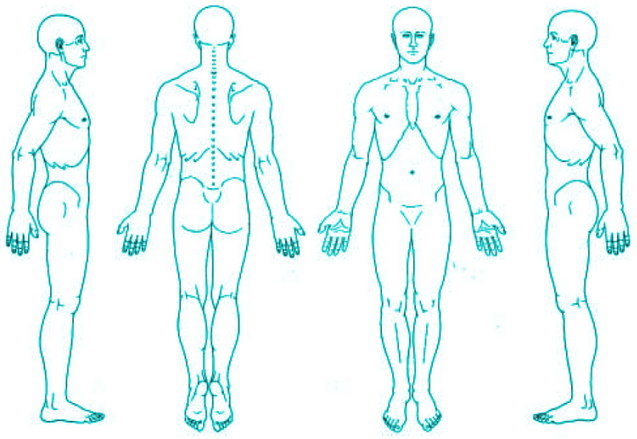
PAIN relieved by rest? YES____ NO_____

Describe OR mark your symptoms:

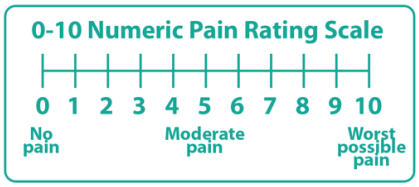
_____

- ☐ Shooting pain
- ☐ Sharp pain
- ☐ Aching pain
- ☐ Dull pain
- ☐ Numbness
- ☐ Tingling

Please mark an X to indicate the areas where you feel pain, swelling, numbness or discomfort. Describe what you feel or observe in your own words. Write anywhere in this area.



On the scales below, please circle the number (0-10) which best represents the severity of your pain:



CURRENT level of pain:

BEST for the last 48 hours:

WORST for the last 48 hours:

My symptoms currently: ____Come and go ____Are constant ____Are constant, but change with activity

Aggravating Factors (positions or activities that make your symptoms worse):_____

_____

Easing Factors (positions or activities that make your symptoms better): _____

_____

How are you currently able to sleep at night due to your symptoms?

☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only with medication

When are your symptoms **worst**?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise

When are your symptoms **the best**?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise

Goal for Therapy: (please complete the sentence)

"I want to reduce my pain, so I can _____"