



Pain Questionnaire

The following are questions your health-care professional might ask you as you begin the diagnosis and treatment process, and at regular intervals over time to see how your treatment is working.

1. Where is your pain located? (check all that apply)

- Head
- Face
- Hand
- Chest
- Upper Back
- Abdomen
- Pelvis
- Buttocks
- Hip
- Genitalia
- Leg
- Foot
- Knee
- Arm
- Ankle
- Neck
- Lower Back
- Shoulder

2. Does your pain move from one area to another?

- Yes
- No

If yes, where? _____

3. In general, would you say your health is:

- Excellent
- Very Good
- Good
- Fair
- Poor

4. During the last week, rate your pain on a scale of 0 to 10.

0 ----- 5 ----- 10
 No pain Moderate pain Severe pain

5. How often do you feel pain?

- Daily
- Other _____
- Weekly
- Monthly

6. What time of day is your pain at its worst?

- Morning
- Noon
- Evening
- Bedtime

7. How long does your pain last?

- _____ Minutes
- _____ Hours
- All Day

8. Which of the following activities do you have trouble doing or are unable to do?

- Running
- Jogging (slow pace)
- Elliptical machine
- Yoga/stretching
- Bicycle riding
- Lifting heavy objects
- Household chores (i.e. vacuuming)
- Sports (i.e., bowling/golfing)
- Sexual intimacy
- Driving
- Doing fine motor activities (typing, gripping, writing)
- Running errands
- Lifting/carrying groceries
- Climbing several flights of stairs
- Climbing one flight of stairs
- Bending/kneeling/stooping
- Walking more than a mile
- Walking several blocks
- Walking one block
- Bathing/dressing myself
- Reaching above my head

8. What relieves your pain?

- Exercise (land/water)
- Rest/sleep
- Stretching/yoga/tai chi
- Cold or heat therapy
- Massage/acupuncture therapy
- Other _____
- Diet change
- Medicine/vitamins/drugs
- Meditation/guided imagery
- Stress reduction

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