Name:

Pain Questionnaire

When did your pain start?---

How did your pain start? Ie gradual, accident---

If this was due to a motor vehicle accident, is ICBC involved or do you have a legal case pending?--

Can you describe your pain ie aching/burning --

Where is your pain? Does it radiate anywhere?---

Has your pain been getting better/worse/staying the same?---

What makes your pain better?--

What makes your pain worse?---

On a scale of 0-10 with 0 being no pain, and 10 being the worst pain you could imagine,

How do you rate your pain on your best day----------- your worst day----------

Do you have any new weakness? ---

Have you tried any of the following treatments? If so, were they successful?

Name:

Physiotherapy--

Chiropractor--

Injections--

Medications--

Surgery--

Do you have any numbness or tingling related to this problem?------------------------------------

Do you have any weakness related to this problem?--

Have you had any investigations for this problem? ie CT, x-ray, MRI. Where and when?----------

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Please tell me about any medical conditions you have--

Please list any surgeries you have had in the past--

Please list your medications--

Please list any drug allergies---

What do you do/did you do for work?---

Do you do a regular exercise program? If so, what type of exercise and how frequently?----------

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Name:

Are you a smoker?--

How much alcohol would you drink in a week?--

What are your hopes for today's visit?---

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

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine

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

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine

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

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine

Please rate your pain by circling the one number that tells how much pain you have **RIGHT NOW**.

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine

In the last 24 hours, how much relief have your pain treatments or medications provided? Please circle the one percentage that shows most how much **RELIEF** you have received.

No relief	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	Complete relief

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

1. **General Activity:**

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

2. **Mood:**

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

3. **Walking Ability:**

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

4. **Normal Work (includes both work outside the home and housework)**

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

5. **Relations with other people:**

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

6. **Sleep:**

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

7. **Enjoyment of Life:**

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes

With permission: Pain Research Group
MD Anderson Cancer Center, 1997

Please circle the area (s) that you have pain.