




PAIN QUESTIONNAIRE

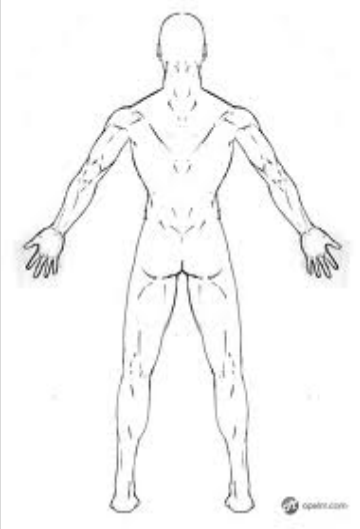
Indicate the quality of your symptoms (mark all that apply):


Constant Intermittent Dull Sharp Ache Other: _____

Is it worse in the: Morning Daytime Evening At work Other: _____

Please indicate the type and location of your pain in the picture(s) below:







Please mark the involved areas on the pictures above as follows:

Pain: #####

Pins & Needles: ::::::::::::::

Numbness: XXXXXXXXXXXXXXXX

Rate your current pain intensity by circling the appropriate number below:



0 = No Pain

0 1 2 3 4 5 6 7 8 9 10

10 = Worst Pain Imaginable



At your best: _____

At your worst: _____

Alleviating & aggravating factors:

What makes your pain better?: _____

What makes your pain worse?: _____

What are your hopes for how therapy can help with your pain?: _____

Your comments: _____

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|--|--|
| Therapists Assessment/Comments: | <input type="checkbox"/> Discussed/re-established pain goal. |
| Therapist Signature: _____ Date: _____ Time: _____ | |