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: XXXXXXXXXXXXXXX

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

0 = No Pain 10 = Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

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: ______________________________

____

Therapists Assessment/Comments: ☐ Discussed/re-established pain goal.

Therapist Signature: ____ Date: ___________Time:_________