Largo Clinic

Name: ____________________

DOB: ____/____/________

MR#: ____________________

Pain Questionnaire

1. Where is your pain? Write in words or use the picture to show where you have pain.

____

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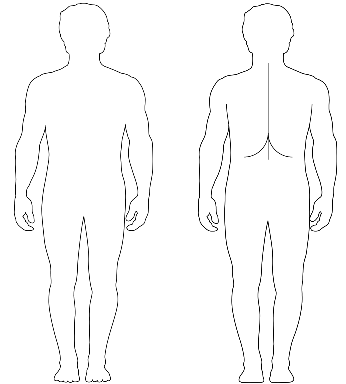

2. Circle the words that describe your pain:

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable

3. Does your pain occur occasionally, frequently or is it constant? (Circle one)

○ Occasionally ○ Frequently ○ Constant

4. What time of day is your pain the worst? (Circle one)

○ Morning ○ Afternoon ○ Evening ○ Nighttime

5. Rate your pain by circling the number that best describes your pain at its **worst** in the last month.

○ No pain ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ Pain as bad as you can imagine

6. Rate your pain by circling the number that best describes your pain at its **least** in the last month.

○ No pain ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ Pain as bad as you can imagine

7. Rate your pain by circling the number that best describes your pain on **average** in the last month.

○ No pain ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ Pain as bad as you can imagine

8. Rate your pain by circling the number that best describes your pain **right now.**

○ No pain ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ Pain as bad as you can imagine

9. What makes your pain **better**? ____

10. What makes your pain **worse**? ____

11. What treatment or medication are you receiving for your pain? If you are not receiving any treatment or medication, circle NONE.

____

____

12. Circle the one number that describes how, during the past week, pain has interfered with your:

a. General Activity	◯ Does Not Interfere	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10	◯ Completely Interferes
b. Mood	◯ Does Not Interfere	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10	◯ Completely Interferes
c. Normal Work	◯ Does Not Interfere	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10	◯ Completely Interferes
d. Sleep	◯ Does Not Interfere	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10	◯ Completely Interferes
e. Enjoyment of Life	◯ Does Not Interfere	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10	◯ Completely Interferes
f. Ability to Concentrate	◯ Does Not Interfere	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10	◯ Completely Interferes
g. Relationships with other People	◯ Does Not Interfere	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10	◯ Completely Interferes

Patient Signature: ______________________________ DOB:______/______/__________

Notes:

☐ No action plan required.

☐ Action plan required. See progress note.

Clinician Signature & Professional Designation ______________________________ DOB:______/______/__________