

## PAIN ASSESSMENT QUESTIONNAIRE

Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### Medical History

A) Year Pain Began: \_\_\_\_\_  
 B) Circumstances of Onset:  
 C)

<input type="checkbox"/> Accident at work	<input type="checkbox"/> Following illness
<input type="checkbox"/> Accident at home	<input type="checkbox"/> Following surgery
<input type="checkbox"/> Other accident	<input type="checkbox"/> Pain “just began”
Comments:	

### **C) Present Drug Intake:**

Medication	Dose	Frequency	Duration of relief	Amount of relief	Date started
Comments, Side Effects:					

### **D) Previous Surgery:**

### **E) Previous Major Illnesses:**

Date	Details

### **F) Previous Physiotherapy/Other treatments:**

Date	Details

### **G) Doctors and Other Health Professionals Consulted Since pain**

<input type="checkbox"/> Allergist	<input type="checkbox"/> Obst./Gyn.
<input type="checkbox"/> Anesthesiologist	<input type="checkbox"/> Ophthalmologist
<input type="checkbox"/> Cardiologist	<input type="checkbox"/> Orthopaedist
<input type="checkbox"/> Dermatologist	<input type="checkbox"/> Pediatrician
<input type="checkbox"/> Ear-Nose-Throat	<input type="checkbox"/> Plastic Surgeon
<input type="checkbox"/> Endocrinologist	<input type="checkbox"/> Proctologist
<input type="checkbox"/> General Practitioner	<input type="checkbox"/> Psychiatrist
<input type="checkbox"/> Internist	<input type="checkbox"/> Radiologist
<input type="checkbox"/> Neurologist	<input type="checkbox"/> Surgeon (General)
<input type="checkbox"/> Dentist	<input type="checkbox"/> Chiropractor
<input type="checkbox"/> Psychologist	<input type="checkbox"/> Acupuncturist
<input type="checkbox"/> Hypnotist	<input type="checkbox"/> Clergy
<input type="checkbox"/> Osteopath	<input type="checkbox"/> Faith Healer

Date	Details

**I) Causes if Increases (+) or Decreases (-) of Pain:**  
 Indicate a “+” or “-“ beside the appropriate cause

Liquor	Sleep, rest
Stimulants (coffee, etc.)	Lying down
Eating	Distraction(tv, etc.)
Heat	Urination, defecation
Cold	Tension
Damp	Bright lights
Weather changes	Loud noises
Massage, vibrator	Going to work
Pressure	Intercourse
No movement	Mild exercise
Movement	Fatigue

**J) Have you learned ways to relax at moments of tension?**

\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, what methods do you use?

**H) PAIN DESCRIPTION:** Choose one word group

Continuous, steady, constant
Rhythmic, periodic, intermittent
Brief, momentary, transient

**L) Work/Activity**

Type of work (include housework:) \_\_\_\_\_

Ability to work at regular job: \_\_\_\_\_

Need to stop all activities because of pain \_\_\_ Yes \_\_\_ No

If “yes” # of times Daily: \_\_\_\_\_ Weekly: \_\_\_\_\_

Comments: \_\_\_\_\_

**M) PRESENT PAIN PATTERN**

a) Throughout the day:

Time	Duration	Time-Pattern
Morning		
Afternoon		
Evening		
Night		

b) Body position: What happens to pain when:

Sitting	
Standing	
Lying	

c) Has your mood changed since pain began? Yes \_\_\_ No \_\_\_

If yes, how?

**K) Pain and Sleep:**

**O) ACCOMPANYING SYMPTOMS**

Nausea	Constipation
Headache	Diarrhea
Dizziness	Menses
Urination	Other

Condition	Always	Sometimes	Never
Trouble falling asleep			
Medication needed to fall asleep			
Awakened by pain			
Comments:	Average hours of sleep:		

Comments:

The following words represent pain-increasing intensity:

1	2	3	4	5	6
No Pain	Mild	Discomforting	Distressing	Horrible	Excruciating

a) Choose the number of the word which best describes:

	Your pain right now
	Your pain at its worst
	Your pain at its least
	The worst toothache you ever had
	The worst headache you ever had
	The worst stomachache you ever had

Indicate pain locations

a) Where does it hurt?

