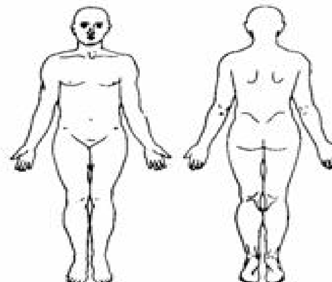
| UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS | BIRTHDATE |
|---|---|
| | NAME |
| **Pain Management Questionnaire** | REG NO |

Date: ___________________



1. **Where do you feel pain?**
   *(shade areas on diagram to the right, put an x where it is worst)*

2. **Please rate your pain 1) at its worst intensity and 2) at its least intensity** *(please circle on the scale below)* **and then 3)place an "X" where your pain is right now.**
   *(Low)* 1 2 3 4 5 6 7 8 9 10 *(High)*

3. **How much has pain interfered with your:**

| | | | | |
|---|---|---|---|---|
| Normal Work | ☐ None | ☐ Some | ☐ A lot | ☐ Completely |
| Home Responsibility | ☐ None | ☐ Some | ☐ A lot | ☐ Completely |
| Hobbies/Recreation | ☐ None | ☐ Some | ☐ A lot | ☐ Completely |
| Social Activity | ☐ None | ☐ Some | ☐ A lot | ☐ Completely |
| Sleep | ☐ None | ☐ Some | ☐ A lot | ☐ Completely |
| Mood | ☐ None | ☐ Some | ☐ A lot | ☐ Completely |

4. **What are your goals for pain management? What do you need, or want to do but cannot because of your pain?**
   ______________________________________________________________________
   ______________________________________________________________________

5. **What new treatments (including medications) have you tried since your last visit?**
   ______________________________________________________________________
   ______________________________________________________________________

6. **How much have treatments (including medications) helped you do what you want, or what you need to do?**
   ☐ None ☐ Some ☐ A lot ☐ Completely

7. **Do you feel you need to take more pain medication than your doctor has prescribed?**
   ☐ Yes ☐ No

8. **Are you having any side effects or constipation from your medication?**
   ☐ Yes ☐ No

9. What exercise have you performed recently? How many times per week? How long each time?

| Type of Exercise | Times per week | How long each time? |
|---|---|---|
| | | |
| | | |

Signature________________________________________ Date______________