Pain Management Questionnaire

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?

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<th>Type of Exercise</th>
<th>Times per week</th>
<th>How long each time?</th>
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Signature_______________________________________  Date_____________