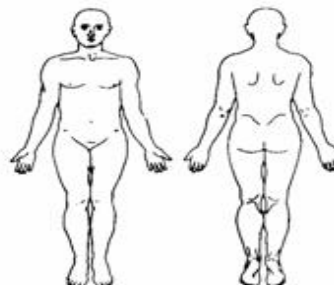


Pain Management Questionnaire

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 | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> A lot | <input type="checkbox"/> Completely |
| Home Responsibility | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> A lot | <input type="checkbox"/> Completely |
| Hobbies/Recreation | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> A lot | <input type="checkbox"/> Completely |
| Social Activity | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> A lot | <input type="checkbox"/> Completely |
| Sleep | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> A lot | <input type="checkbox"/> Completely |
| Mood | <input type="checkbox"/> None | <input type="checkbox"/> Some | <input type="checkbox"/> A lot | <input type="checkbox"/> 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 _____