Name:

DOB:

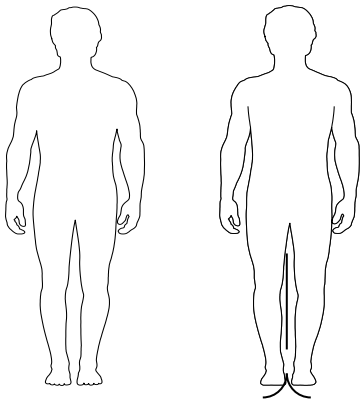
Pinellas Pain and Palliative Care

Pain Questionnaire

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

   _____

   _____



2. Is your pain job related? Yes No Accident related? Yes No
3. What type of brace do you wear and how long have you worn this?
4. Do you use a cane or walker or another assistive device?
5. Circle the words that describe your pain.

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

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

   Occasionally Frequently Constant

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

   Morning Afternoon Evening Nighttime

8. *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

9. *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

10. R*ate 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

11. *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

12. *What makes your pain **better**?* _____

13. *What makes your pain **worse**?* _____

14. *What treatment or medication are you receiving for your pain?*

_____

15. *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 _____ Date: ___/ ___/ _____

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Anything else you would like Dr Williams to address during your visit:

_____

_____

_____

Patient Signature _____ Date: ___ /___ / _____