Pain Survey

Name: _____ **Date:** _____

When did your pain begin? (Give date if possible): _____

Is your pain related to an injury? Yes No

Auto accident (date of accident: _____)

On the job work injury (date of injury: _____)

Other (describe): _____

Describe the quality/character of your pain. (Check all that apply)

Aching Burning Cold Electric shocks Dull Hot/Flushed

Lightning-like Numb Pins & Needles Sharp Stabbing Throbbing

Tingling Other (describe): _____

Describe the frequency of your pain.

Daily Weekly Monthly Constant

Infrequent/episodic/irregular (describe): _____

Describe the duration of your pain. (Check all that apply)

Seconds Minutes Hours Days Weeks Months Constant

Rate the severity of your pain on this scale (Circle one)

1----------2----------3----------4----------5----------6----------7----------8----------9----------10

(1 = mild, 10 = intense/severe/worst pain of your life)

What makes your pain worse?

What makes your pain better?

The information on this form provided by the patient and/or family members was personally reviewed and/or amended by me.

_____ _____

Provider Signature **Date**

---------- Continued on reverse side ----------

Mark the areas on you body where you feel pain or abnormal/uncomfortable sensations(s).

FRONT **BACK**

(body silhouette) **(body silhouette)**

FRONT **BACK**

(face/head silhouette) **(face/head silhouette)**