PAIN ASSESSMENT QUESTIONNAIRE

Patient Name: _____ **DOB:**_____

Where is your pain? _____

1. **Date of pain onset:** _____
2. **How often does it occur?** □ Chronic □ Intermittent
3. **How long does it last?** □ Minutes □ Hours □ Days □ Everyday □ All day and night
4. **Describe how the pain feels:**

   □ Sharp □ Aching □ Throbbing □ Stabbing □ Burning □ Tingling

   □ Numbness □ Pressure □ Wringing □ Other:_____

5. **Severity:** On a scale of 0 to 10, with 0 being no pain and 10 being worst pain possible:
   - **What number would you give your pain now? _____**
   - **Most severe in past 24 hours? _____**
   - **At your best (least pain)? _____**

NONE	ANNOYING		UNCOMFORTABLE			DREADFUL		HORRIBLE	AGONY	
0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain				Moderate Pain		Severe Pain	Extreme Pain		Worst

6. **Aggravating Factors: What makes your pain worse?**

   □ Sitting □ Standing □ Bending □ Lifting □ Walking □ Turning

   □ Twisting □ Lying down □ Driving □ Position □ Extension □ Activity

   □ Inactivity □ Movement □ Other:_____

7. **Alleviating Factors: What makes your pain better?**

   □ Heat □ Cold □ Massage □ Medication □ Distraction □ Manipulation

   □ Music □ Prayer □ Meditation □ Other:_____

_____ _____

Patient's Signature **Date**