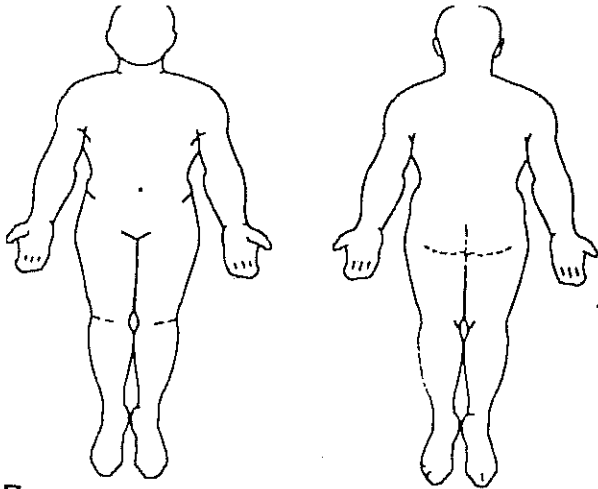


**BETH ISRAEL DEACONESS HOSPITAL - MILTON
PAIN QUESTIONNAIRE**



1. On the diagram, shade in the areas where you feel pain. Put an "X" on the area that hurts the most

2. Please rate your pain by circling the one number that best describes your pain at its **WORST**.
 0 1 2 3 4 5 6 7 8 9 10
 No Pain Pain as bad as you can imagine.

3. Please rate your pain by circling the one number that best describes your pain at its **LEAST**.
 0 1 2 3 4 5 6 7 8 9 10
 No Pain Pain as bad as you can imagine.

4. Please rate your pain by circling the one number that best describes your pain at its **AVERAGE**.
 0 1 2 3 4 5 6 7 8 9 10
 No Pain Pain as bad as you can imagine.

5. Please rate your pain by circling the one number that tells how much pain you have **RIGHT NOW**.
 0 1 2 3 4 5 6 7 8 9 10
 No Pain Pain as bad as you can imagine.

6. What kinds of things make your pain feel better (i.e. heat, medicine, rest)?

7. What kinds of things make your pain feel worse (i.e. walking, standing, lifting)?

8. Are you currently receiving any other treatment for your pain (i.e. acupuncture, chiropractor)? NO YES If YES, what type?

9. For each of the following words circle the adjectives which apply to your pain.

- | | | | | |
|--------|-------------|----------|------------|-------------|
| ACHING | THROBBING | SHOOTING | STABBING | GNAWING |
| SHARP | TENDER | BURNING | EXHAUSTING | PENETRATING |
| TIRING | NAGGING | NUMB | MISERABLE | UNBEARABLE |
| DULL | OTHER _____ | | | |

Patient Signature: _____ Date: _____ Time: _____

For Therapist Only: Additional Comments: _____

Therapist Signature: _____ Date: _____ Time: _____