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 your body where you feel pain or abnormal/uncomfortable sensations(s).

FRONT

(body silhouette)

BACK

(body silhouette)

FRONT

(face/head silhouette)

BACK

(face/head silhouette)