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INSTRUCTIONS

PLEASE READ AND ANSWER ALL OF THE QUESTIONS. PRINT YOUR ANSWERS CLEARLY. IF YOU NEED MORE SPACE FOR ANY OF YOUR ANSWERS, YOU MAY WRITE ON THE BACK SIDE OF THE PAGE.

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

1. Briefly describe your pain problem: _____

2. Circle a number between 0 (no pain) and 10 (the most intense pain imaginable) which describes the level of your pain at its:

Highest intensity: 0 1 2 3 4 5 6 7 8 9 10

Usual intensity: 0 1 2 3 4 5 6 7 8 9 10

Lowest intensity: 0 1 2 3 4 5 6 7 8 9 10

Your pain level at this very moment: 0 1 2 3 4 5 6 7 8 9 10

3. Circle a number between 0 (no interference) and 10 (continuous interference) which describes how much your pain interferes with the following activities:

Work: 0 1 2 3 4 5 6 7 8 9 10

Family chores: 0 1 2 3 4 5 6 7 8 9 10

Play, recreation: 0 1 2 3 4 5 6 7 8 9 10

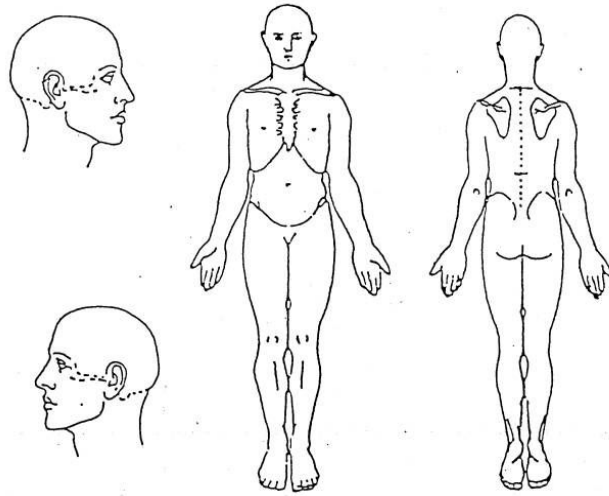
Sex: 0 1 2 3 4 5 6 7 8 9 10

What is the percentage of time that you are in pain (0 to 100): _____%

What makes your pain worse? _____

What eases or reduces your pain? _____

Use the figures on the following page to indicate (1) Where the pain is located, (2) How much area is involved, (3) Whether there is more than one location, (4) Do your sensations spread? If so, show where they spread by writing an "X" at the main area of pain and draw arrow to show how the symptoms spread.



What other medical problems do you have? _____

Please complete the table below for any surgeries you have had:

Date of Surgery	Type of Surgery	Age	Complications (if any)

List all of the doctors involved in your medical care:

Doctor's Name	Specialty	Type of Treatment	Dates of Treatment/Frequency of Visits

Do you have any history of drug/alcohol abuse problems? _____ Yes _____ No

On the lines below and on the back of this page if necessary, please list any questions or other information about your pain problem that you think is important for us to know as part of your evaluation. _____

