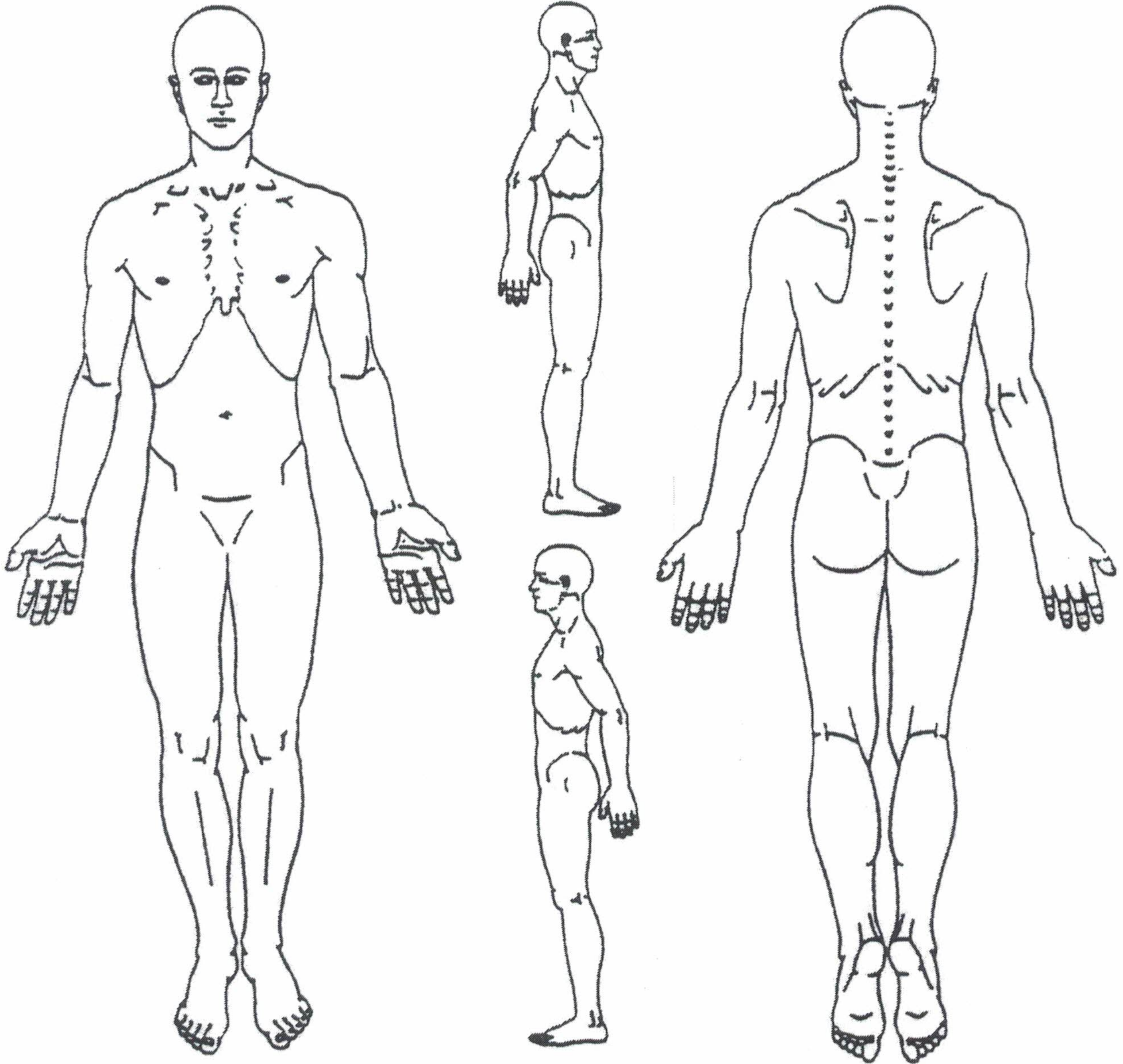
# Pain Drawing

Name: ______________________

Mark the location of your pain on the body outlines below.



# Head Pain Questionnaire

**Please Only Fill This Form Out If YOU Are Experiencing This Pain!**

**If You Do Not Have This Pain Then Skip This Form!**

1. Where in your Head are you feeling pain?

   Front Back Left Side Right Side

2. How would you rate the level of your pain you feel right now on a scale of 1 to 10? **One is no pain, ten is severe pain.**

   1 2 3 4 5 6 7 8 9 10

3. What is the frequency of pain? How often do you feel the pain?

   0-25% 25-50% 50-75% 75-100%

4. When the pain is at its worst what number would you rate it?
   **One is no pain, ten in severe pain.**

   1 2 3 4 5 6 7 8 9 10

5. When the pain is at its best what number would you rate it?

   **One is no pain, ten in severe pain.**

   1 2 3 4 5 6 7 8 9 10

6. Does your pain refer to any of the following areas?

| Neck | Face | Jaw | Eyes |
|---|---|---|---|
| Left-Right or Both | Left-Right or Both | Left-Right or Both | Left-Right or Both |

7. What relieves your pain?

   Rest Ice Heat Stretching Medicine type: ___________

8. When you do get relief what percentage does your pain improve?

0-25%  25-50%  50-75% 75-100%

9. How would you describe the pain?

Sharp  Dull  Achy  Stiff  Tight  Burning  Numb

10. When is the pain at its worst?

Morning  Afternoon  Evening  All Day

11. What caused this pain? What were you doing when you first felt the pain?

______________________________________________________________________

______________________________________________________________________

12. How long have you been experiencing this pain? Please be specific.

Since the Accident  ___days  ___weeks  ___months  ___years

# Neck Pain Questionnaire

**Please Only Fill This Form Out If YOU Are Experiencing This Pain!**

**If You Do Not Have This Pain Then Skip This Form!**

1. Where in your neck are you feeling pain?

   Front Back Left Side Right Side

2. How would you rate the level of your pain you feel right now on a scale of 1 to 10? **One is no pain, ten is severe pain.**

   1 2 3 4 5 6 7 8 9 10

3. What is the frequency of pain? How often do you feel the pain?

   0-25% 25-50% 50-75% 75-100%

4. When the pain is at its worst what number would you rate it?
   **One is no pain, ten in severe pain.**

   1 2 3 4 5 6 7 8 9 10

5. When the pain is at its best what number would you rate it?

   **One is no pain, ten in severe pain.**

   1 2 3 4 5 6 7 8 9 10

6. Does your pain refer to any of the following areas?

| Head | Shoulders | Arms | Hands |
|---|---|---|---|
| Left-Right or Both | Left-Right or Both | Left-Right or Both | Left-Right or Both |

7. What relieves your pain?

   Rest Ice Heat Stretching Medicine type: __________

8. When you do get relief what percentage does your pain improve?

   0-25% 25-50% 50-75% 75-100%

9. How would you describe the pain?

Sharp    Dull    Achy    Stiff    Tight    Burning    Numb

10. When is the pain at its worst?

Morning    Afternoon    Evening    All Day

11. What caused this pain? What were you doing when you first felt the pain?

______________________________________________________________________

______________________________________________________________________

12. How long have you been experiencing this pain? Please be specific.

Since the Accident    ___days    ___weeks    ___months    ___years

# Upper/Mid Back Pain Questionnaire

**Please Only Fill This Form Out If YOU Are Experiencing This Pain!**

**If You Do Not Have This Pain Then Skip This Form!**

1. Where in your Upper or Mid back are you feeling pain?

   Left Side    Right Side

2. How would you rate the level of your pain you feel right now on a scale of 1 to 10? **One is no pain, ten is severe pain.**

   1  2  3  4  5  6  7  8  9  10

3. What is the frequency of pain? How often do you feel the pain?

   0-25%    25-50%    50-75%    75-100%

4. When the pain is at its worst what number would you rate it?
   **One is no pain, ten in severe pain.**

   1  2  3  4  5  6  7  8  9  10

5. When the pain is at its best what number would you rate it?

   **One is no pain, ten in severe pain.**

   1  2  3  4  5  6  7  8  9  10

6. Does your pain refer to any of the following areas?

| chest | ribs | shoulders | Other:___________ |
|---|---|---|---|
| Left-Right or Both | Left-Right or Both | Left-Right or Both | Left-Right or Both |

7. What relieves your pain?

   Rest    Ice    Heat    Stretching    Medicine type: __________

8. When you do get relief what percentage does your pain improve?

0-25%    25-50%    50-75%    75-100%

9. How would you describe the pain?

Sharp    Dull    Achy    Stiff    Tight    Burning    Numb

10. When is the pain at its worst?

Morning    Afternoon    Evening    All Day

11. What caused this pain? What were you doing when you first felt the pain?

______________________________________________________________________

______________________________________________________________________

12. How long have you been experiencing this pain? Please be specific.

Since the Accident    ___days    ___weeks    ___months    ___years

# Lower Back Pain Questionnaire

**Please Only Fill This Form Out If YOU Are Experiencing This Pain!**

**If You Do Not Have This Pain Then Skip This Form!**

1. Where in your lower back are you feeling pain?

   Front Back Left Side Right Side

2. How would you rate the level of your pain you feel right now on a scale of 1 to 10? **One is no pain, ten is severe pain.**

   1 2 3 4 5 6 7 8 9 10

3. What is the frequency of pain? How often do you feel the pain?

   0-25% 25-50% 50-75% 75-100%

4. When the pain is at its worst what number would you rate it? **One is no pain, ten in severe pain.**

   1 2 3 4 5 6 7 8 9 10

5. When the pain is at its best what number would you rate it?

   **One is no pain, ten in severe pain.**

   1 2 3 4 5 6 7 8 9 10

6. Does your pain refer to any of the following areas?

| Hips | Buttocks | Front of legs | Back of legs |
|---|---|---|---|
| Left-Right or Both | Left-Right or Both | Left-Right or Both | Left-Right or Both |

7. What relieves your pain?

   Rest Ice Heat Stretching Medicine type: __________

8. When you do get relief what percentage does your pain improve?

0-25%  25-50%  50-75%  75-100%

9. How would you describe the pain?

Sharp  Dull  Achy  Stiff  Tight  Burning  Numb

10. When is the pain at its worst?

Morning  Afternoon  Evening  All Day

11. What caused this pain? What were you doing when you first felt the pain?

______________________________________________________________________

______________________________________________________________________

______________

12. How long have you been experiencing this pain? Please be specific.

Since the Accident  ___days  ___weeks  ___months  ___years

# Shoulder Pain Questionnaire

## Please Only Fill This Form Out If YOU Are Experiencing This Pain!

## If You Do Not Have This Pain Then Skip This Form!

1. Where in your Shoulders are you feeling pain?

   Front Back Left Side Right Side

2. How would you rate the level of your pain you feel right now on a scale of 1 to 10?
   **One is no pain, ten is severe pain.**

   1 2 3 4 5 6 7 8 9 10

3. What is the frequency of pain? How often do you feel the pain?

   0-25% 25-50% 50-75% 75-100%

4. When the pain is at its worst what number would you rate it?
   **One is no pain, ten in severe pain.**

   1 2 3 4 5 6 7 8 9 10

5. When the pain is at its best what number would you rate it?

   **One is no pain, ten in severe pain.**

   1 2 3 4 5 6 7 8 9 10

6. Does your pain refer to any of the following areas?

| Neck | Arms | Forearms | Hands |
|---|---|---|---|
| Left-Right or Both | Left-Right or Both | eft-Right or Both | Left-Right or Both |

7. What relieves your pain?

   Rest Ice Heat Stretching Medicine type: __________

8. When you do get relief what percentage does your pain improve?

   0-25% 25-50% 50-75% 75-100%

9. How would you describe the pain?

Sharp Dull Achy Stiff Tight Burning Numb

10. When is the pain at its worst?

Morning Afternoon Evening All Day

11. What caused this pain? What were you doing when you first felt the pain?

_______________________________________________

_______________________________________________

12. How long have you been experiencing this pain? Please be specific.

Since the Accident ___days ___weeks ___months ___years

# Hand Questionnaire

**Please Only Fill This Form Out If YOU Are Experiencing This Pain!**

**If You Do Not Have This Pain Then Skip This Form!**

1. Which Hand are you feeling pain? Left Right Both

   Where in your hand are you feeling pain?

   Top Bottom

2. How would you rate the level of your pain you feel right now on a scale of 1 to 10?
   **One is no pain, ten is severe pain.**

   1 2 3 4 5 6 7 8 9 10

3. What is the frequency of pain? How often do you feel the pain?

   0-25% 25-50% 50-75% 75-100%

4. When the pain is at its worst what number would you rate it?
   **One is no pain, ten in severe pain.**

   1 2 3 4 5 6 7 8 9 10

5. When the pain is at its best what number would you rate it?

   **One is no pain, ten in severe pain.**

   1 2 3 4 5 6 7 8 9 10

6. What relieves your pain?

   Rest Ice Heat Stretching Medicine type: ___________

7. When you do get relief what percentage does your pain improve?

   0-25% 25-50% 50-75% 75-100%

8. How would you describe the pain?

Sharp Dull Achy Stiff Tight Burning Numb

9. When is the pain at its worst?

Morning Afternoon Evening All Day

10. What caused this pain? What were you doing when you first felt the pain?

______________________________________________

______________________________________________

11. How long have you been experiencing this pain? Please be specific.

Since the Accident ___days ___weeks ___months ___years

# Knee Pain Questionnaire

## Please Only Fill This Form Out If YOU Are Experiencing This Pain!

## If You Do Not Have This Pain Then Skip This Form!

1. Where in your Knees are you feeling pain?

   Front Back Left Side Right Side

2. How would you rate the level of your pain you feel right now on a scale of 1 to 10?
   **One is no pain, ten is severe pain.**

   1 2 3 4 5 6 7 8 9 10

3. What is the frequency of pain? How often do you feel the pain?

   0-25% 25-50% 50-75% 75-100%

4. When the pain is at its worst what number would you rate it?
   **One is no pain, ten in severe pain.**

   1 2 3 4 5 6 7 8 9 10

5. When the pain is at its best what number would you rate it?

   **One is no pain, ten in severe pain.**

   1 2 3 4 5 6 7 8 9 10

6. Does your pain refer to any of the following areas?

| Thigh | Knees | Calves | Feet |
| --- | --- | --- | --- |
| Left-Right or Both | Left-Right or Both | Left-Right or Both | Left-Right or Both |

7. What relieves your pain?

   Rest Ice Heat Stretching Medicine type: __________

8. When you do get relief what percentage does your pain improve?

   0-25% 25-50% 50-75% 75-100%

9. How would you describe the pain?

Sharp Dull Achy Stiff Tight Burning Numb

10. When is the pain at its worst?

Morning Afternoon Evening All Day

11. What caused this pain? What were you doing when you first felt the pain?

______________________________________________________________________

______________________________________________________________________

12. How long have you been experiencing this pain? Please be specific.

Since the Accident ___days ___weeks ___months ___years

# Foot Questionnaire

**Please Only Fill This Form Out If YOU Are Experiencing This Pain!**

**If You Do Not Have This Pain Then Skip This Form!**

1. Which foot are you feeling pain? Left Right Both

   Where in your Feet are you feeling pain?

   Top Bottom Left Side Right Side

2. How would you rate the level of your pain you feel right now on a scale of 1 to 10?
   **One is no pain, ten is severe pain.**

   1 2 3 4 5 6 7 8 9 10

3. What is the frequency of pain? How often do you feel the pain?

   0-25% 25-50% 50-75% 75-100%

4. When the pain is at its worst what number would you rate it?
   **One is no pain, ten in severe pain.**

   1 2 3 4 5 6 7 8 9 10

5. When the pain is at its best what number would you rate it?

   **One is no pain, ten in severe pain.**

   1 2 3 4 5 6 7 8 9 10

6. What relieves your pain?

   Rest Ice Heat Stretching Medicine type: ___________

7. When you do get relief what percentage does your pain improve?

   0-25% 25-50% 50-75% 75-100%

8. How would you describe the pain?

Sharp Dull Achy Stiff Tight Burning Numb

9. When is the pain at its worst?

Morning Afternoon Evening All Day

10. What caused this pain? What were you doing when you first felt the pain?

______________________________________________________________________________

______________________________________________________________________________

11. How long have you been experiencing this pain? Please be specific.

Since the Accident ___days ___weeks ___months ___years

## Activities Discomfort Scale

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

| Activity | Doesn't Hurt At All | Hurts A Little | Hurts Very Much | Almost Unbearable | Unbearable Pain Prevents Activity |
|---|---|---|---|---|---|
| 1. Walking | | | | | |
| 2. Sitting | | | | | |
| 3. Bending | | | | | |
| 4. Standing | | | | | |
| 5. Sleeping | | | | | |
| 6. Lifting | | | | | |
| 7. Running or jogging | | | | | |
| 8. Climbing Stairs | | | | | |
| 9. Carrying | | | | | |
| 10. Pushing or Pulling | | | | | |
| 11. Driving | | | | | |
| 12. Dressing | | | | | |
| 13. Reading | | | | | |
| 14. Watching TV | | | | | |
| 15. Household Chores | | | | | |
| 16. Gardening | | | | | |
| 17. Sports | | | | | |
| 18. Employment | | | | | |

ADDITIONAL COMMENTS:

PATIENT NAME ______________________ PATIENT SIGNATURE ______________________

EXAMINER ______________________ DATE ____________ Score ____________ [72]

Turner JA, Robinson J, McCreary CP. Chronic low back pain: Predicting response to nonsurgical treatment. *Arch Phys Med Rehabilitation* 1983; 64: 560-563

# The Back Bournemouth Questionnaire

Name: ______________________ Date: ______________________

The following scales have been designed to find out about your back pain and how it is affecting you. Please answer **ALL** the scales by circling **ONE** number on each scale that best describes how you feel:

1. Over the past week, on average, how would you rate your back pain?

No pain worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing lifting, reading, and driving)?

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

0 1 2 3 4 5 6 7 8 9 10

5. Over the pasted week, how depressed (down-in-the-dumps, sad, low spirits, pessimistic, unhappy) have you been feeling?

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain.

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

0 1 2 3 4 5 6 7 8 9 10

The Neck Bournemouth Questionnaire

Name: ______________________________ Date: ______________________________

The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer **ALL** the scales by circling **ONE** number on each scale that best describes how you feel:

1. Over the past week, on average, how would you rate your neck pain?

No pain — worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing lifting, reading, and driving)?

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

0 1 2 3 4 5 6 7 8 9 10

5. Over the pasted week, how depressed (down-in-the-dumps, sad, low spirits, pessimistic, unhappy) have you been feeling?

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain.

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

0 1 2 3 4 5 6 7 8 9 10