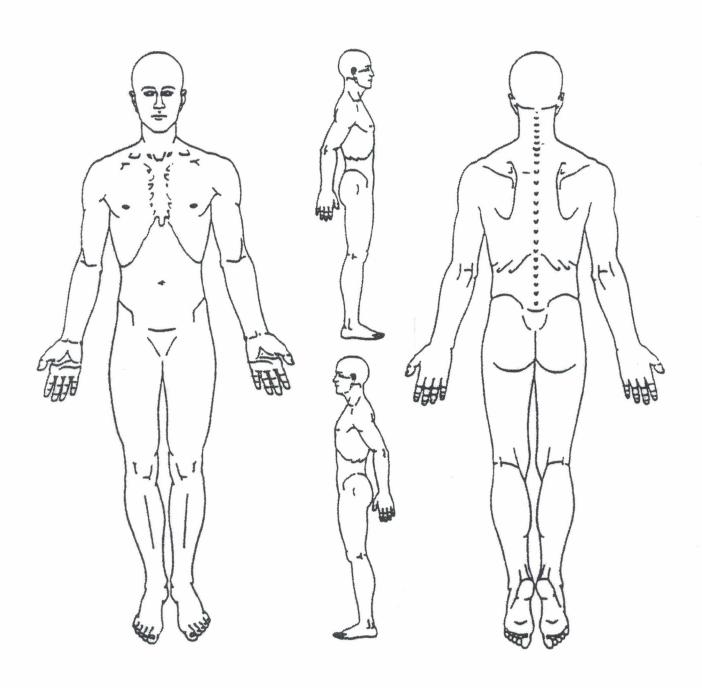
### Pain Drawing

Name:	
Mame.	

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!

1.	Where in y	our Hea	d are yo	u feeling	g pain?						
		Fron	nt	1	Back		Left Side		Right Si	ide	
2.	How woul	d you ra	te the lev	el of yo			right now	on a	scale of	1 to 10? <b>O</b> n	ne is no pai
		1 2	3	4	5	6	7	8	9	10	
3.	What is th	e freque	ncy of pa	in? Hov	v often do	you f	eel the pair	n?			
			0-	-25%	2:	5-50%	650-75%7	5-100	%		
4.	When the	pain is a	t its wor			-	ou rate it? n severe p	ain.			
	1	2	3	4	5	6	7	8	9	10	
5.	When the	pain is a	t its best	what nu	ımber wou	ld yo	u rate it?				
			(	One is n	o pain, te	n in s	evere pain	١.			
	1	2	3	4	5	6	7	8	9	10	
6.	Does your	pain ref	er to any	of the f	following a	ıreas?					
Neck				Face			Jav	V		Eye	s
Left-Righ	t or Both		Lef	t-Right o	or Both		Left-Righ	nt or E	Both	Left-Righ	t or Both
7.	What relie	ves you	r pain?								
		Rest ]	Ice I	Heat S	Stretching		Medicine 1	ype:			

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.	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 Accidentdaysweeksmonthsyears												

### Neck Pain Questionnaire

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

	** 71				0 11								
1	. Wh	ere in yo	our ne	ck are you	teelin	ig pain?							
			Fre	ont		Back		Left Side		Right Sid	de		
2	. Ho	w would	you r	ate the lev	el of y			l right now ere pain.	on a	scale of 1	to 10? One is	no pain,	
		1	2	3	4	5	6	7	8	9	10		
3	. Wh	at is the	frequ	ency of pa	in? Ho	ow often do	you :	feel the pai	n?				
				0-25%		25-50%		50-75%		75-100%	6		
4	. Wh	en the pa	ain is	at its wors	st what	number wo	uld v	ou rate it?					
	One is no pain, ten in severe pain.												
		1	2	3	4	5	6	7	8	9	10		
5	. Wh	en the pa	ain is	at its best	what n	number wou	ld yo	ou rate it?					
				(	)ne is	no pain, ter	in s	severe pair	1.				
		1	2	3	4	5	6	7	8	9	10		
6	. Do	es your p	ain re	efer to any	of the	following a	reas	?					
	Head			9	Should	ers		Ar	ms	F	lands		
Left-I	Right o	or Both		Le	ft-Rig	ht or Both		Left-Ri	ght or	Both I	Left-Right or E	Both	
7	. Wh	at reliev	es you	ur pain?									
		R	est	Ice I	leat	Stretching		Medicine	type: _		necessarian and		
R	. Wh	ien vou d	lo get	relief who	it nerce	entage does	VOIII	nain impr	ove?				
0	. **1	ion you c		25%	•	5.50%		-75%		-100%			
			11	130/0	1		71	m / 30/0	13	111111/0			

9.	How would	Sharp Dull Achy Stiff Tight Burning Numb  When is the pain at its worst?  Morning Afternoon Evening All Day  What caused this pain? What were you doing when you first felt the pain?											
		Sharp	Dull	Achy	Stiff	Tight	Burning	Numb					
10.	0. When is the pain at its worst?												
	Morning Afternoon Evening All Day												
,11.	What cause	d this pa	in? Wha	t were yo	ou doing	g when yo	u first felt	the pain?					
	annonen annone	***************************************	***************************************		***************************************	***************************************	***************************************						
10	** **		1					~					
12.	How long h	iave you	been ex	periencin	ig this p	ain? Pleas	se be speci	fic.					
	Sin	ce the A	ccident		days	weeks	mo	nthsyears					

#### Upper/Mid Back Pain Questionnaire

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

FO.	rm!									
1.	Where in	your U	pper or	Mid bac	k are you	feeli	ng pain?			
				]	Left Side	Rig	ght Side			
2.	How wor	uld you	rate the	level of			feel right no		n a scale of	1 to 10? <b>One is n</b>
	1	2	3	4	5	6	7	8	9	10
3.	What is t	he frequ	iency of	pain? F	low often	do y	ou feel the p	ain?		
		0-3	25%		25-50%		50-75%		75-100%	
4.	When the	e pain is	at its w				ld you rate i in severe pa			
	1	2	3	4	5	6	7	8	9	10
5.	When the	e pain is	at its be	est what	number v	vould	you rate it?	)		
			(	)ne is no	o pain, te	n in s	evere pain			
	1	2	3	4	5	6	7	8	9	10
6.	Does you	ır pain r	efer to a	iny of th	e followii	ng are	eas?			
ch	nest		ribs	S		sho	ulders		Other:	
Left-Rig	ght or Both	Le	eft-Righ	t or Botl	h l	Left-I	Right or Bot	h	Left-	Right or Both
7.	What reli	eves yo	ur pain?	,						
	Re	est Ic	e H	leat S	tretching		Medicine ty	ype:		a a

8.	When you do get relief what percentage does your pain improve?  0-25% 25-50% 50-75% 75-100%											
	0-25%	25-50%	50-75%	75-100%								
9.	How would you describe th	ne pain?										
	Sharp Dull	Achy Stiff	Tight Burning	g Numb								
10.	10. When is the pain at its worst?											
	Morning Afternoon Evening All Day											
11.	. What caused this pain? Wh	at were you do	ing when you first	felt the pain?								
12.	How long have you been ex	xperiencing this	s pain? Please be s	pecific.								
	Since the Accident	days _	weeksm	onthsyears								

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

<b>*</b>	Where	in you	ır lower b	ack are	you feeli	ng pa	in?						
		Fron	nt		Back		Left Side		Right Side				
2.	How w	vould y	ou rate tl	ne leve	l of your p is no pain	ain yo	ou feel right is severe pa	now	on a scale	of 1 to 10? <b>O</b>	ne		
	1	2	3	4	5	6	7	8	9	10			
3.	What is	s the fi	requency	of pain	? How oft	en do	you feel the	e pai	n?				
		0-	-25%		25-50%		50-75%		75-100%				
4.	When t	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 t	he pai	n is at its	best w	hat numbe	r wou	ıld you rate	it?					
			О	ne is n	o pain, te	n in s	evere pain.						
	1	2	3	4	5	6	7	8	9	10			
6.	Does yo	our pa	in refer to	any of	f the follow	wing a	areas?						
Hips			Buttock	S		Fro	ont of legs		Back	c of legs			
Left-Right	or Both	L	eft-Right	or Bot	h I	_eft-R	light or Bot	h	Left-F	Right or Both	l		
7.	What re	elieves	your pai	n?									
	Res	st I	ce He	eat S	Stretching		Medicine ty	pe:					

8.	When you do get relie	ef what percentag	e does your pain i	mprove?									
	0-25%	25-50%	50-75%	75-100%									
9.	How would you descr	ribe the pain?											
	Sharp Dull	Achy Stiff	Tight Burnin	ng Numb									
10.	0. 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 be	een experiencing	this pain? Please	be specific.									
	Since the Accident	days	weeksn	nonthsyears									

### Shoulder Pain Questionnaire

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

	1.	Where in	your S	houlder	s are you	u feeling p	pain?					
			F	ront		Back		Left Sic	le	Right Sid	e	
	2	2. How w	ould yo	ou rate th		of your pa				a scale of	1 to 10?	
			1 2	3	4	5	6	7	8	9	10	
	3.	What is t	he frequ	uency of	pain? I	How often	do you	feel the p	ain?			
				0-25%		25-50	%	50-759	%	75-100%		
	4.	When the	e pain is	s at its w		at number 1e is no pa						
		1	2	3	4	5	6	7	8	9	10	
	5.	When the	pain is	at its be	est what	number v	vould yo	u rate it?				
					One i	s no pain,	ten in s	evere pa	in.			
		1	2	3	4	5	6	7	8	9	10	
	6.	Does you	r pain r	efer to a	ny of th	e followir	ng areas'	>				
Neck				Arms			F	orearms			Н	ands
Left-Rig	ght o	r Both	Le	ft-Right	or Both	1	eft-	Right or	Both		Left-Ri	ght or Both
	7.	What reli	eves yo	ur pain?								
			Rest	Ice	Heat	Stretchin	ng	Medicino	e type:		and and a second	
	8.	When you	u do get	t relief w	hat per	centage do	es your	pain imp	rove?			
			0-	-25%	2	25-50%	50	-75%	75	-100%		

9.	How would	you des	cribe the	pain?									
		Sharp	Dull	Achy	Stiff	Tight	Burning	Numb					
10.	10. When is the pain at its worst?												
	Morning Afternoon Evening All Day												
11.	11. What caused this pain? What were you doing when you first felt the pain?												
	444646644	***************************************	***************************************		******************************	******************************	***************************************						
12.	12. How long have you been experiencing this pain? Please be specific.												
	Sine	ce the A	ccident	d	lays _	weeks	moi	nthsyears					

### Hand Questionnaire

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

1.	Which Hand	l are you	u feeling	pain?	Left	Right	Both	ı						
			WI	nere in yo	our hand	are you	feeling	pain?						
	Top Bottom													
2	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	frequenc	y of pain	? How o	ften do y	ou feel	the pain	?						
		0-2	25%	25	5-50%	50	)-75%	75-	100%					
4.	pulled the world will be would you late it:													
	One is no pain, ten in severe pain.													
	groond	2	3	4	5	6	7	8	9	10				
5.	When the pa	in is at i	ts best wl	nat numb	er woul	d you rat	te it?							
			On	e is no p	ain, ten	in sever	e pain.							
	1	2	3	4	5	6	7	8	9	10				
6.	What relieve	s your p	ain?											
	Re	st Ice	Hea	it Stre	tching	Med	licine ty	pe:	***************************************					
7.	When you do	o get reli	ef what r	ercentag	e does v	our pain	improv	e?						
	•	0-25%		25-50%		50-75%	*	75-100	0/0					
		V 111 V /	-	mw ww/		00-10/	o .	15-100	/ 0					

8.	How would you describe the pain?									
		Sharp	Dull	Achy	Stiff	Tight	Burning	Numb		
9.	When is the	pain at i	ts worst'	?						
		Morr	ning	After	noon	Eveni	ng	All Day		
10.	What caused	d this pai	n? What	were yo	u doing	when you	u first felt	the pain?		
1.1	**									
11.	How long ha	ave you b	been exp	eriencing	g this pa	in? Pleas	e be speci	fic.		
	Sinc	e the Ac	cident	d	ays	weeks	moi	nthsyears		

### Knee Pain Questionnaire

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

1.	Where in	your Kne	es are yo	ou feeling	g pain?					
	Front			E	Back Left S				Right Side	<b>;</b>
ž	2. How would you rate the level of your pain you feel right now on a scale of One is no pain, ten is severe pain.									to 10?
		1 2	3	4	5	6	7	8	9	10
3.	What is th	e frequer	icy of pa	in? How	often do	you f	eel the pai	in?		
		0	-25%		25-50%		50-75%		75-100%	
4.	When the	pain is at	its wors				ou rate it? n severe p			
	1	2	3		5	6	7	8	9	10
							٠			10
5.	When the	pain is at	its best	what nur	nber wou	ld you	rate it?			
			O	ne is no	pain, tei	n in se	evere pair	1.		
	1	2	3	4	5	6	7	8	9	10
6.	Does your	pain refe	r to any	of the fo	llowing a	reas?				
Thigh		k	Cnees				Calves			Feet
Left-Right o	or Both	Left-	Right or	Both		Left	-Right or	Both		Left-Right or Both
prop	XX7141'-		. 0							
7.	What relie	ves your	pain?							
	1	Rest Ic	e H	eat St	retching	Many	Medicine 1	ype:	***************************************	
8.	When you	do gat ra	liefwhai	narrant	aga dana	¥78%×¥44		0,000		
3.	ii iicii you	0-25		25-50		,	75%		-100%	

9.	How would you describe the pain?										
		Sharp	Dull	Achy	Stiff	Tight	Burning	Numb			
10.	When is the	pain at i	ts worst'.	?							
	Morning Afternoon Evening All Day										
11.	1. What caused this pain? What were you doing when you first felt the pain?										
	***************************************	***************************************	***************************************	***************************************	***************************************	***************************************	***************************************				
12.	2. How long have you been experiencing this pain? Please be specific.										
	Sinc	e the Ac	ecident	d	ays	weeks	mo	nthsyears			

### Foot Questionnaire

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

1.	Which foot are	you feelin	g pain?	Left	Righ	t Bo	th					
	Where in your Feet are you feeling pain?											
	Top Bottom Left Side Right Side											
2	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	2 3	4	5	6	7	8	9	10			
3.	What is the free	quency of	pain? Ho	w often do	you fe	el the pai	n?					
		0-25%		25-50%		50-75%		75-100%				
4.	4. When the pain is at its worst what number would you rate it?  One is no pain, ten in severe pain.											
	1 2	2 3	4	5	6	7	8	9	10			
5.	When the pain	is at its be	st what n	umber wou	d you	rate it?						
			One is r	10 pain, ter	in se	vere pain	١.	9				
	1 2	2 3	4	5	6	7	8	9	10			
6.	What relieves y	our pain?										
	Rest	Ice	Heat	Stretching	N	Aedicine t	ype:					
7.	When you do g	et relief w	hat perce	ntage does	vour r	ain impro	ve?					
		0-25%		·50%		75%		-100%				

8.	How would you describe the pain?										
		Sharp	Dull	Achy	Stiff	Tight	Burning	Numb			
9.	When is the	pain at i	ts worst'	?							
		Mor	ning	After	noon	Eveni	ng	All Day			
10.	0. What caused this pain? What were you doing when you first felt the pain?										
11	How long h	ave you l	heen eyn	arianain	a this no	ing place	. 1	c .			
	Tion long ii	ave you	occii exp	erienem	g uns pa	in? Pieas	e be speci	nc.			
	Sine	ce the Ac	cident	d	ays	weeks	mo	nthsyears			

#### **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				***************************************	
ADDI	TIONAL COMMENTS:					
******************		***************************************				
***************************************						
PATIE	ENT NAME		PATIEN	T SIGNATURE		
EXAM	INER		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:							
you. I	ollowing Please a ou feel:	nswer A	have be	en desi e scales	gned to by circl	find ou	t about E numl	your ba ber on e	ck pain ach sca	and hor le that b	w it is affecting est describes		
1. Ov	er the p	oast wee	ek, on av	verage,	how wo	ould you	ı rate yo	our back	c pain?				
	No pa	in								worst	pain possible		
	0	1	2	3	4	5	6	7	8	9	10		
2. (house	Over t	he past washing	week, h	ow mung liftin	ch has y g, readi	our bac ng, and	ek pain driving	interfere g)?	ed with	your da	ily activities		
	0	1	2	3	4	5	6	7	8	9	10		
3. in recr	Over t	he past l, social	week, h	ow mu	ch has y tivities?	our bac	ek pain	interfere	ed with	your ab	ility to take part		
	0	1	2	3	4	5	6	7	8	9	10		
4. Ove have y	er the parou beer	st week n feeling	t, how a g?	nxious	(tense, ı	uptight,	irritable	e, diffic	ulty in	concent	rating/relaxing)		
	0	1	2	3	4	5	6	7	8	9	10		
5. unhap	Over t	he paste e you be	ed week een feel	, how ding?	epresse	d (dowr	n-in-the	-dumps	, sad, lo	w spirit	s, pessimistic,		
	0	1	2	3	4	5	6	7	8	9	10		
6. affecte			week, h fect) you			elt your	work (ł	ooth ins	ide and	outside	the home) has		
	0	1	2	3	4	5	6	7	8	9	10		
7. pain o	Over t		week, h	ow mue	ch have	you bed	en able	to contr	ol (redu	ice/help	) your back		
	0	1	2	3	4	5	6	7	8	9	10		

#### The Neck Bournemouth Questionnaire

Name:						Date:							
you.	ollowing Please a rou feel:	inswer.	have be	een desi	igned to by circ	find ou	ut about NE num	your notes	eck pair each sca	n and ho	ow it is affecting best describes		
1.	Over t	he past	week, o	n avera	ge, how	would	you rat	te your	neck pa	in?			
	No pa	in								worst	pain possible		
	0	1	2	3	4	5	6	7	8	9	10		
2. (house	Over t	the past washing	week, l g, dressi	now mu ng liftir	ich has g	your ne	ck pain l drivin	interferg)?	ed with	your da	aily activities		
	0	1	2	3	4	5	6	7	8	9	10		
3. in recr	Over t	the past l, socia	week, l	now mu mily ac	ch has y	your ne	ck pain	interfer	ed with	your ab	pility to take part		
	0	1	2	3	4	5	6	7	8	9	10		
4. concer	Over to	he past /relaxin	week, h	ow anx	tious (te en feeli	ense, up ng?	tight, ir	ritable,	difficul	ty in			
	0	1	2	3	4	5	6	7	8	9	10		
5. unhap <sub>l</sub>	Over t	he paste e you b	ed week een feel	, how ding?	lepresse	d (dow	n-in-the	e-dumps	s, sad, lo	ow spiri	ts, pessimistic,		
	0	1	2	3	4	5	6	7	8	9	10		
6. affecte	Over t	he past ould af	week, h	ow hav ur neck	e you fe pain.	elt your	work (	both ins	ide and	outside	the home) has		
	0	1	2	3	4	5	6	7	8	9	10		
7. pain or	Over to	he past own?	week, h	ow muc	ch have	you be	en able	to contr	rol (redi	uce/help	) your neck		
	0	1	2	3	4	5	6	7	8	9	10		