

## Pain Questionnaire

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please answer the following questions about your condition:

When did you notice the pain growing or begin to have functional limitations due to the pain?

\_\_\_\_\_

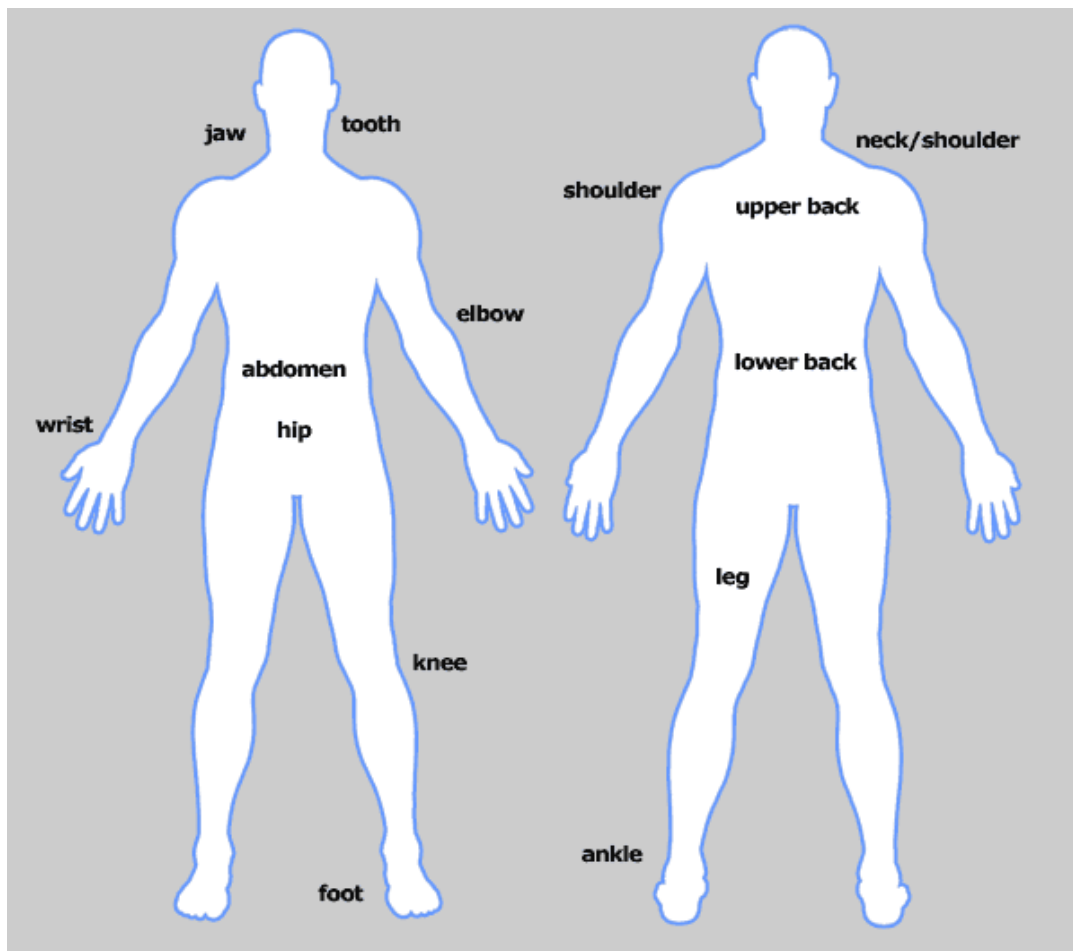
How did your symptoms begin (what were you doing?) \_\_\_\_\_

Was the pain sudden or a gradual onset? \_\_\_\_\_

What are two functional goals you would like to achieve? 1. \_\_\_\_\_ 2. \_\_\_\_\_

Please mark on the diagram where your symptoms are located using the symbols below

= Numbness + Tingling \*Sharp/Shooting pain ))) Swelling ^^^ Dull ache



**Please indicate your level of pain on the following scale with 10 being the worst pain**

- Currently
- With Activity
- At rest
- Worst in last month
- Least in last month

**Are your symptoms currently?**

- Worse
- Better
- Same
- Constant
- Intermittent

**Are you currently taking any medications? If so, please list.**

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**INFORMED CONSENT TO PHYSICAL THERAPY (PT):** Prior to treatment, patient acknowledges understanding and has been advised of condition, assessment, treatment risks/benefits with/without treatment, proposed alternatives, and patient goals. Patient understands exercises programs, activities modifications or treatment in PT may be part of the treatment plan. Pt agrees to fully participate in program. Repeated cancellations may result in program discontinuation. Patient consents to recommended PT treatment plan.

PT Initials \_\_\_\_\_ Patient Signature \_\_\_\_\_