Pain Assessment & Symptom Questionnaire

Please complete this form to help us assess your pain, its characteristics, and its impact on your daily life.

Patient Information

Please provide your personal and contact information.

Full Name *

First Name Last Name

Date of Birth *

Month Day Year

Today's Date *

Month Day Year

Phone Number *

Please enter a valid phone number.

Email Address *

Primary Pain Complaint

Describe your main pain concern.

Main area of pain *

When did the pain begin? *

How did the pain start? *

Pain onset *

- ◯ Sudden
- ◯ Gradual
- ◯ Unknown

Pain Scale

Please rate your pain on a scale of 0 (no pain) to 10 (worst pain imaginable).

Current pain level (0-10) *

Worst pain level (0-10) *

Least pain level (0-10) *

Average pain level (0-10) *

Pain Description

Select all words that describe your pain.

Which of the following describe your pain? *

- ☐ Sharp
- ☐ Dull
- ☐ Aching

- [ ] Throbbing
- [ ] Burning
- [ ] Shooting
- [ ] Stabbing
- [ ] Cramping
- [ ] Tingling
- [ ] Numb
- [ ] Radiating
- [ ] Pressure
- [ ] Tightness
- [ ] Constant
- [ ] Intermittent
- [ ] Other

If you selected 'Other', please describe:

Pain Pattern

Please indicate your pain pattern.

How often do you experience the pain? *

- ◯ Constant
- ◯ Comes and goes (intermittent)
- ◯ Only with certain activities

Do you have pain at night? *

- ◯ Yes
- ◯ No

Does the pain affect your sleep? *

- ◯ Yes
- ◯ No

Do you experience stiffness? *

- ◯ Yes
- ◯ No

Is your pain getting better, worse, or staying the same? *

- ◯ Better
- ◯ Worse
- ◯ No change

Pain Location

Describe where you feel the pain.

Please describe the location(s) of your pain: *

Aggravating Factors

What makes your pain worse?

Which of the following make your pain worse? *

- ☐ Movement
- ☐ Standing
- ☐ Sitting
- ☐ Walking
- ☐ Exercise
- ☐ Lifting
- ☐ Cold weather
- ☐ Hot weather
- ☐ Stress
- ☐ Other

Please describe any other aggravating factors:

Relieving Factors

What helps relieve your pain?

Which of the following help relieve your pain? *

- ☐ Rest
- ☐ Heat
- ☐ Cold
- ☐ Medication
- ☐ Massage
- ☐ Physical therapy
- ☐ Position change
- ☐ Other

Please describe any other relieving factors:

Associated Symptoms

Select any symptoms you experience along with your pain.

Which of the following symptoms do you experience? *

- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Swelling
- ☐ Fever
- ☐ Weight loss
- ☐ Other

Please describe any other associated symptoms:

Impact on Daily Function

How does your pain affect your daily activities?

Which of the following are affected by your pain? *

- ☐ Work
- ☐ Household tasks
- ☐ Exercise
- ☐ Sleep
- ☐ Social activities
- ☐ Personal care
- ☐ Other

Please describe any other impacted activities:

Medical & Treatment History

Tell us about your relevant medical history.

Current medications (please list): *

Have you had prior treatment for this pain? (e.g., physical therapy, injections, surgery) *

Have you had any imaging (X-ray, MRI, CT scan) for this pain? *

- ◯ Yes
- ◯ No

If yes, please describe the imaging and findings:

Red Flag Screening

Check any of the following that apply.

Do you have any of the following?

- ☐ Recent trauma or injury
- ☐ History of cancer
- ☐ Unexplained weight loss
- ☐ Fever or chills
- ☐ Night sweats
- ☐ Loss of bowel or bladder control
- ☐ Numbness in groin area
- ☐ Other

Please describe any other red flag symptoms:

Consent & Verification

Please read and confirm the following.

I confirm that the information provided is accurate to the best of my knowledge. *

☐ I agree

Signature Section

Please provide your signature to verify this submission.

Printed Name *

Date *

Month Day Year