0603: Questionnaire on Pain

Please answer the following questions to the best of your ability.

1. Describe in your own words:

A. When did it begin?

B. Where is it located?

C. Has it changed in nature and/or location since it began?

D. Does it spread to other places

2. Is the pain constant? Yes_____ No_____

If “no”:

A. How often does it occur?

B. What brings it on?

C. How long does it last?

3. Do you take any medication to relieve your pain? Yes_____ No_____

If “yes”:

A. What is the medication called?

B. What is the name of the doctor who prescribes the medication?

C. What was the prescribed dosage?

D. How much do you take?

4. Have you ever taken any other kind(s) of medication? Yes_____ No_____
If you have, what was the medication and why did you stop or change medication?

5. Do you wear or use any devices to relieve the pain or its effects? Yes_____ No_____
If so, please describe:

A. Describe any other things you do or use to relieve the pain.

6. What are your usual activities (walking, shopping, household chores, driving, socializing, etc.)
On a typical day?

In a typical week?

7. Has the pain affected your activities? Yes_____ No_____ If yes, please describe how:

8. When did the pain first begin to affect your activities?

9. Is there anyone else who has knowledge about the pain and its impact on you? Yes_____ No_____ (Please give name(s), address, phone number)

10. Please provide your height and weight:

Height: _____feet _____ inches Weight: _____pounds