PAIN QUESTIONNAIRE SINCE YOUR DISABILITY BEGAN

Please complete the following questions for your primary area or source of pain. If you have secondary or additional source of pain, please also complete the Supplemental Pain Questionnaire. Please explain your answers by giving us detailed examples. If you need more room, you may use more sheets of paper. Be sure to sign and date this form at the end in the space provided.

1. Please describe the pain that prevents you from carrying out your normal day. Be specific.

   a. When did it begin?

   b. Where is it currently located?

   c. Has it changed in nature and/or location since it began? ☐ Yes ☐ No If YES, how has it changed?

   d. Does it spread to other places? ☐ Yes ☐ No If YES, where?

   e. Is the pain constant? ☐ Yes ☐ No If NO, how often does it occur?

      What brings it on?

      How long does it last?

2. Do you take pain medication(s) for your condition? ☐ Yes ☐ No If YES, please list the name of medication, amount currently taken, how often taken and how long used.

   a. Does the medication relieve the pain? ☐ Yes ☐ No If YES, how soon? For how long?

   b. Does the medication cause any side effects? ☐ Yes ☐ No If YES, please describe.

3. Please describe any devices worn or used to relieve the pain.

4. Please describe any other things done to relieve the plain.

5. When did the pain first begin to affect activities?

6. Please describe any change in activities since the pain began.

7. Please describe current daily activities. (Walking, shopping, household chores, driving, socializing, etc.)

8. Are there any other statements you wish to make about the pain?

9. Please list anyone, other than doctors (we may contact) who has knowledge about the effects of this pain:

   NAME ADDRESS PHONE NUMBER

NOTE: If you do not have secondary source or area of pain, skip to Page 4.

SUPPLEMENTAL PAIN QUESTIONNAIRE

(For secondary or additional sources, or areas of pain)

1. Please describe the pain that prevents you from carrying out your normal day. Be specific.

   a. When did it begin?

   b. Where is it currently located?

   c. Has it changed in nature and/or location since it began? ☐ Yes ☐ No If YES, how has it changed?

   d. Does it spread to other places? ☐ Yes ☐ No If YES, where?

   e. Is the pain constant? ☐ Yes ☐ No If NO, how often does it occur?

      What brings it on?

      How long does it last?

2. Do you take pain medication(s) for your condition? ☐ Yes ☐ No If YES, please list the name of medication, amount currently taken, how often taken and how long used.

   c. Does the medication relieve the pain? ☐ Yes ☐ No If YES, how soon? For how long?

   d. Does the medication cause any side effects? ☐ Yes ☐ No If YES, please describe.

3. Please describe any devices worn or used to relieve the pain.

4. Please describe any other things done to relieve the plain.

5. When did the pain first begin to affect activities?

6. Please describe any change in activities since the pain began.

7. Please describe current daily activities. (Walking, shopping, household chores, driving, socializing, etc.)

8. Are there any other statements you wish to make about the pain?

9. Please list anyone, other than doctors (we may contact) who has knowledge about the effects of this pain:

   NAME ADDRESS PHONE NUMBER

_____
YOUR NAME

_____
YOUR SIGNATURE

_____
DATE