STEINDLER
ORTHOPEDIC CLINIC

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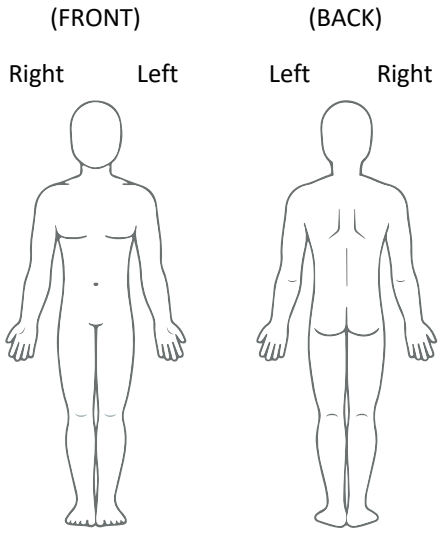
FJD/DBG

Name_____ Date_____ Account Number_____

1. Throughout our lives, most of us have pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today? **Yes** **No**

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



PAIN SCALE
0 – No Pain
1 – Hardly notice pain
2 – Notice pain, does not interfere with activities
3 – Sometimes distracts me
4 – Distracts me, can do usual activities
5 – Interrupts some activities
6 – Hard to ignore, avoid usual activities
7 – Focus of attention, prevents doing daily activities
8 – Awful, hard to do anything
9 – Can't bear the pain, unable to do anything
10 – As bad as it could be, nothing else matters

3. Please rate your pain by circling the one number that best describes your pain at its WORST in the last 7 days.

0 1 2 3 4 5 6 7 8 9 10

No Pain **Pain as bad as as you can imagine**

4. Please rate your pain by circling the one number that best describes your pain at its LEAST in the last 7 days.

0 1 2 3 4 5 6 7 8 9 10

No Pain **Pain as bad as as you can imagine**

5. Please rate your pain by circling the one number that best describes your pain on AVERAGE over the last week**.**

0 1 2 3 4 5 6 7 8 9 10

No Pain **Pain as bad as as you can imagine**

6. Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0 1 2 3 4 5 6 7 8 9 10

No Pain **Pain as bad as as you can imagine**

7. What treatments or medications are you receiving for your pain? _____

_____ **(Continue to next side)**

8. Have you done physical therapy before? **Yes** **No**

If so, when? _____

9. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much RELIEF you have received.

0% **10** **20** **30** **40** **50** **60** **70** **80** **90** **100%**

No Relief **Complete Relief**

What does the pain feel like? Circle the words that describe your pain.
aching throbbing shooting stabbing squeezing cramping deep gnawing pricking sharp tender burning dull radiating exhausting penetrating nagging numb miserable unbearable tingling pins/needles

How long have you had this pain? (circle one)
Less than a week 1-2 weeks 3-4 weeks
*more then 4 weeks If so, how long?_____

What kinds of things make your pain feel better (i.e., heat, medicine, rest)?_____

_____

What kinds of things make your pain worse (i.e., walking, standing, lifting)?_____

_____

Do you have any other symptoms? Circle any that apply?
nausea vomiting constipation diarrhea lack of appetite indigestion difficulty sleeping headaches feeling drowsy nightmares dizziness tiredness itching urinary problems sweating

10. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity
0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere — Completely Interferes

B. Mood
0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere — Completely Interferes

C. Walking ability
0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere — Completely Interferes

D. Normal work (includes both work outside the home and housework)
0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere — Completely Interferes

E. Relations with other people
0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere — Completely Interferes

F. Sleep
0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere — Completely Interferes

G. Enjoyment of life
0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere — Completely Interferes