Florida Center
for Headache & Sports Neurology

Pain Questionaire

Patient Name	Date

When and How did your problem begin?

Where Does it Hurt? Also give your pain a score on a scale of 0 to 10, with 10 being the worst pain and 0 being no pain.
As far as you know what is the cause of your pain?

What Doctors have you seen? And When did you see them?

Name	Month and Year Seen
1.	
2.	
3.	
4.	

What tests and studies have been done? And what were the results?		
Test	**Date**	**Results**

Check all the words that describe your pain.
❑Aching ❑Sharp ❑Penetrating ❑Nagging ❑Tender
❑Throbbing ❑Shooting ❑Burning ❑Numb ❑Stabbing
❑Gnawing ❑Continuous ❑Intermittent ❑Unbearable

What non medication related activities make your pain better?
❑Standing ❑ Sitting ❑Lying ❑Physical Therapy ❑Rest
❑Heat ❑ Ice ❑Tens Unit ❑Other _____

What makes your pain worse?				
❑Standing	❑ Sitting	❑Lying	❑Walking	❑Bending
❑Reaching	❑Grabbing	❑Lifting	❑Pulling	❑ Pushing
❑Other ____				

What medications have you tried for your pain and how well did they work?		
Medication	**No Relief----------------------Complete Relief**	**Still Taking** **Yes or No**
	0 — 1— 2— 3— 4— 5— 6— 7— 8— 9-- 10	
	0 — 1— 2— 3— 4— 5— 6— 7— 8— 9-- 10	
	0 — 1— 2— 3— 4— 5— 6— 7— 8— 9-- 10	
	0 — 1— 2— 3— 4— 5— 6— 7— 8— 9-- 10	
	0 — 1— 2— 3— 4— 5— 6— 7— 8— 9-- 10	
	0 — 1— 2— 3— 4— 5— 6— 7— 8— 9-- 10	
	0 — 1— 2— 3— 4— 5— 6— 7— 8— 9-- 10	
	0 — 1— 2— 3— 4— 5— 6— 7— 8— 9-- 10	
	0 — 1— 2— 3— 4— 5— 6— 7— 8— 9-- 10	

Please rate your disability from your pain		
No Disability	**Moderate Disability**	**Unable to function**
0 --------- 1 --------- 2 --------- 3 --------- 4 -------- 5 -------- 6 ------- 7 --------8 -------- 9 -------- 10		