

Pain Questionnaire

Please fill out the following questions regarding your pain experience.

On a scale of 0 to 10, how would you rate your pain right now? (0 = no pain, 10 = worst pain imaginable) *

0 1 2 3 4 5 6 7 8 9 10

No Pain

Worst Pain

What makes your pain better? (Select all that apply)

- Rest
- Ice/Heat Therapy
- Medication
- Massage
- Stretching/Yoga
- Other

What makes your pain worse? (Select all that apply)

- Movement
- Weather Changes
- Stress
- Lack of Sleep
- Exercise
- Other

What type of medication do you take for your pain?

How much medication do you take? (Please specify dosage and frequency)

Does the medication help alleviate your pain? *

Yes

No

What triggers your pain? (Select all that apply)

Lack of Sleep

Increased Stress

Exercise

Dietary Choices

Other

Additional Comments or Notes