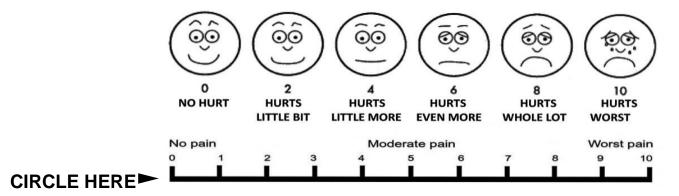
## HealthCare Pain Management PAIN QUESTIONNAIRE

Name:	Date:

**CIRCLE** the number/s below that best describes the level of pain that you experienced over the last **5-7 DAYS**. Indicate a range of pain, at its BEST and at its WORST, within the last **5-7 DAYS**. A Pain Scale of 10 represents the most UNIMAGINABLE UNSPEAKABLE PAIN, comparable to CRUSHING A HAND AND PASSING OUT AS A RESULT OF PAIN. There is no greater pain than the right end of the scale. In other words, there is no score of "15" on a scale from 0 to 10.



What makes your pain vall that applies) prolonged sitting prolonged standing walking lifting objects bending forward bending backwards OTHERS:	reaching upwards reaching upwards head turning computer work hange in weather laying down		
What relieves your pain: (Please check all that applies) sitting laying down on my back laying down on my side stretching painful part hot packs ice or BenGay massage medications OTHERS:			
Do you have numbness or tingling in any body part? YESNO  If Yes, where? What have you tried to relieve your pain: (Please check all that applies) Home Exercise, Stretching, Gym Physical Therapy, Chiropractor Motrin, Aleve, Ibuprofen, Muscle Relaxers			

On the body diagram below, **DARKLY** shade the area that shows us where in your body the pain is mostly concentrated in; LIGHTLY shade areas where the pain may spread or radiate to.

