



Advanced Integrative Medicine
Pain Questionnaire

Patient Name _____ Age _____ Date _____

Diagnosis _____

This questionnaire has been designed to tell us more about your pain. This questionnaire will cover four main topics:

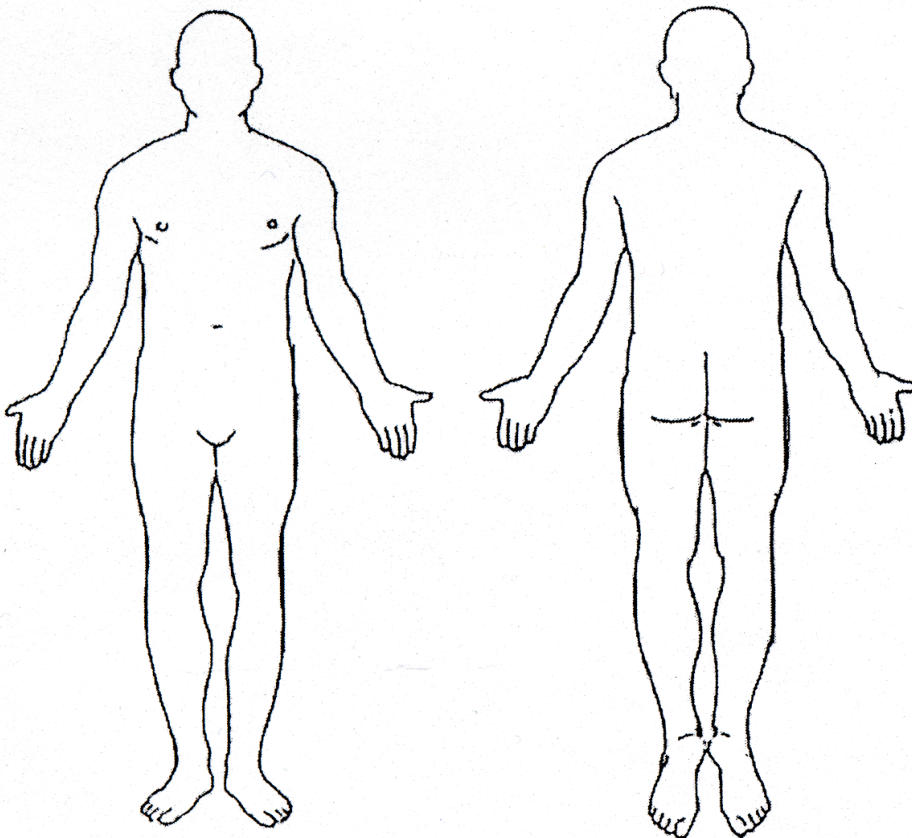
1. Where is your pain?
2. What does it feel like?
3. How does it change with time?
4. How strong is it?

It is important to tell us how your pain feels now using the diagram below. Look next to the diagram to the number chart. Pick the number or numbers that represent the type of pain you are experiencing. Place those numbers on the diagram in the area where you are experiencing that type of pain.

1. Where is your pain?

2. What does your pain feel like?

Place these numbers on the diagram to represent your pain:



- | | | | |
|--|--|--|---|
| 1
flickering
quivering
pulsing | 2
jumping
flashing
shooting | 3
pricking
boring
drilling | 4
sharp
cutting
lacerating |
| 5
pinching
pressing
gnawing
cramping
crushing | 6
tugging
pulling
wrenching | 7
hot
burning
scalding
searing | 8
tingling
itchy
smarting
stinging |
| 9
dull
sore
hurting
aching
heavy | 10
tender
taut
rasping
splitting | 11
tiring
exhausting | 12
sickening
suffocating |
| 13
fearful
frightful
terrifying | 14
punishing
grueling
cruel
vicious
killing | 15
wretched
blinding | 16
annoying
troublesome
miserable
intense
unbearable |
| 17
spreading
radiating
penetrating
piercing | 18
tight
numb
drawing
squeezing
tearing | 19
cool
cold
freezing | 20
nagging
nauseating
agonizing
dreadful
torturing |

Please complete the questions on the back of the questionnaire.

