PAIN QUESTIONNAIRE

***PAIN*: (If you have pain on only one side, you can skip questions related to the other side.)**

Where is your pain located? _____

What side is your pain on?

☐Left ☐Right ☐Midline If Bilateral: ☐Equal ☐Left greater than Right ☐Right greater than Left

---

How long have you had this problem?

Please specify how many days, weeks, months, or years:_____

Did you have an acute event or trauma that caused this problem? If so, please describe it:

If injured, what was the date of injury? _____

What does the pain feel like? (Mark all that apply or describe it yourself on the blank line provided)

☐Dull ☐Achy ☐Sharp ☐A baseline dull and achiness with episodes of sharp pain
☐Throbbing ☐Burning ☐Stabbing ☐Like electricity

Other: _____

Does the pain radiate? Yes / No. If yes, where does it radiate to? _____

How severe is your pain? (Circle one.) 0 is no pain and 10 is worst pain of your life.

SCALE OF PAIN: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

What makes the pain worse: (Mark all that apply or describe it yourself on the blank line provided)

☐Ascending stairs ☐Descending stairs ☐Arising from a chair ☐Kneeling or squatting ☐Laying on side of hip
☐Walking ☐Exercise ☐Getting in/out of a car ☐Putting on shoes and socks ☐Pushing on side of hip
☐Overhead activity ☐Bending over ☐Twisting ☐Pivoting

☐Other: _____

What makes the pain better: (Mark all that apply or describe it yourself on the blank line provided)

☐Rest ☐Sitting ☐Standing ☐Lying down ☐Stretching
☐Pain medications ☐Topical ointments ☐Topical patches ☐Ice ☐Heat ☐Nothing

☐Other: _____

Do you have a history of back pain? Yes / No. Do you have sciatica? Yes / No

If yes, please explain:_____

What have you (or your other doctors) tried to improve your pain? (Mark all that apply or describe it yourself below)

☐Weight loss ☐NSAIDs ☐Tramadol ☐Tylenol ☐Physical therapy
☐Cane/Walker ☐Glucosamine ☐Cortisone injections

☐Other: _____