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Chronic Pain Questionnaire

Pain Intensity

Circle your **current** pain intensity with “0” representing no pain and “10” the most severe pain imaginable.

0 1 2 3 4 5 6 7 8 9 10

Circle your **average** pain score the last 7 days.

0 1 2 3 4 5 6 7 8 9 10

Circle your **best** pain score the last 7 days.

0 1 2 3 4 5 6 7 8 9 10

Circle your **worst** pain score the last 7 days.

0 1 2 3 4 5 6 7 8 9 10

What level of pain control do you consider satisfactory?

0 1 2 3 4 5 6 7 8 9 10

Functional Limitations

How many blocks can you walk before having to stop secondary to pain? _____
blocks.

How many hours or minutes can you sit before having to get up and move about? _____ hrs
_____ mins.

How many hours or minutes can you stand before having to sit down? _____ hrs
_____ mins.

How often during the day to do you lie down because of pain?

Since your last visit, indicate any activities that **have improved with use of pain medications**.

- Going to work
- Performing household chores
- Shopping or doing yard work
- Socializing with friends
- Sleep
- Physically exercising
- Overall Functioning

Please also indicate any activities that **remain significantly limited due to pain**.

- Going to work
- Performing household chores
- Shopping or doing yard work
- Socializing with friends
- Sleep
- Physically exercising
- Overall Functioning

Side Effects

Please indicate any side effects you have concerns about.

- Sleepiness or drowsiness
- Constipation
- Nausea or vomiting
- Itchiness
- Dizziness
- Sexual function
- Physical dependence, tolerance to pain medications, or addiction