RETURN VISIT PAIN QUESTIONNAIRE

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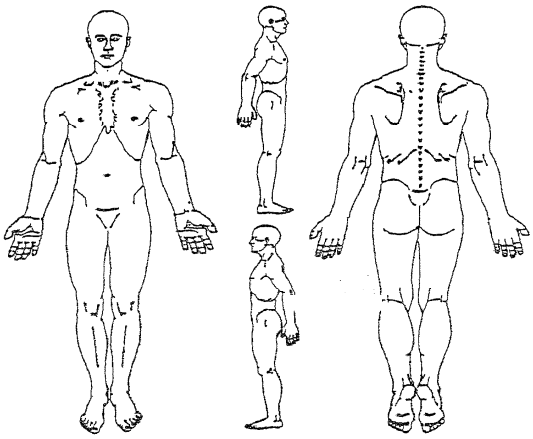
Name: _____

Date: _____ Age: _____ DOB: _____

Ht. _____ Wt. _____ BP _____ HR _____

INDICATE PAIN LOCATIONS: Where does it hurt? Indicate on the figure below



McGill Short Form Pain Questionnaire
Please indicate degree that each of the following word descriptors apply to you pain.

	None	Mild	Moderate	Severe
Throbbing	0)_____	1)_____	2)_____	3)_____
Shooting	0)_____	1)_____	2)_____	3)_____
Stabbing	0)_____	1)_____	2)_____	3)_____
Sharp	0)_____	1)_____	2)_____	3)_____
Cramping	0)_____	1)_____	2)_____	3)_____
Gnawing	0)_____	1)_____	2)_____	3)_____
Hot-Burning	0)_____	1)_____	2)_____	3)_____
Aching	0)_____	1)_____	2)_____	3)_____
Heavy	0)_____	1)_____	2)_____	3)_____
Tender	0)_____	1)_____	2)_____	3)_____
Splitting	0)_____	1)_____	2)_____	3)_____
Tiring-exhausting	0)_____	1)_____	2)_____	3)_____
Sickening	0)_____	1)_____	2)_____	3)_____
Fearful	0)_____	1)_____	2)_____	3)_____
Punishing-cruel	0)_____	1)_____	2)_____	3)_____

How helpful was your recent treatment or medication change?

0 1 2 3 4 5 6 7 8 9 10
not at all all of the time

Medication	Type of reaction

ACTIVITIES OF DAILY LIVING SHORT FORM QUESTIONNAIRE

Does your pain interfere with your ability to manage your personal grooming (bathing, dressing, combing your hair, etc.)?

0 1 2 3 4 5 6 7 8 9 10
not at all — all of the time

Does your pain interfere with your ability to drive or ride in a car?

0 1 2 3 4 5 6 7 8 9 10
not at all — all of the time

Does your pain interfere with your ability to walk?

0 1 2 3 4 5 6 7 8 9 10
not at all — all of the time

Does your pain interfere with your ability to work or complete your usual activities such as housework or school?

0 1 2 3 4 5 6 7 8 9 10
not at all — all of the time

Does your pain interfere with your ability to visit and enjoy family and friends?

0 1 2 3 4 5 6 7 8 9 10
not at all — all of the time

Have you been depressed because of your pain?

0 1 2 3 4 5 6 7 8 9 10
not at all — all of the time

Does your pain interfere with your ability to sleep?

0 1 2 3 4 5 6 7 8 9 10
not at all — all of the time

MEDICAL HISTORY

What medicines are you taking regularly right now (please include Vitamins, Herbs & Supplements)?

Medicines	Does	How often?