MKK Healthcare Inc
Kona Family Health Center
Pain Questionnaire

Name:_____ Date:_____

Please circle all answers that apply:

1. Is this the 1st episode of this pain: (circle) yes no

2. How long have you had this pain: ____years ____months ____weeks ____days

3. Have you had an X-ray or an MRI for this problem? yes no

   If yes, approximate date_____

4. Last flare up of this pain began: ____/____/____ (estimate date)

5. Pain Intensity at its worst: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (screaming pain)

6. Pain Intensity at its best: 0 1 2 3 4 5 6 7 8 9 10

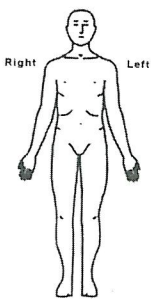
7. Pain Frequency: How many times per: ____day _____week _____month _____year

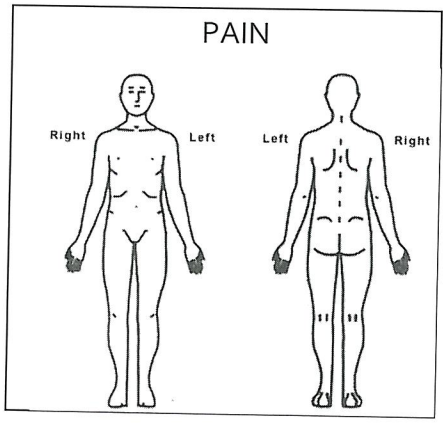
8. Pain Quality: sharp, dull, more of an ache, burning, comes & goes, constant, radiates down arm (left, right, or both), radiates down leg (left, right, or both), same area, moves around, getting better, worse, no change since began

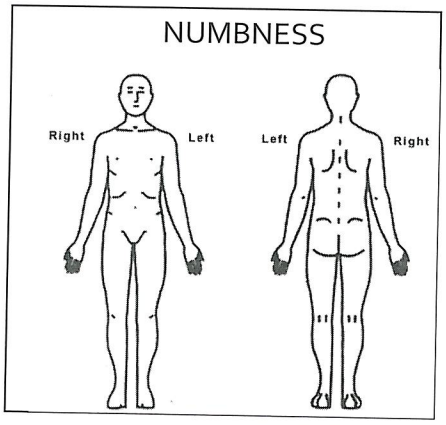
9. Pain increased by: sitting, standing, lifting, bending over, walking, sleeping, work, exercise, squatting down, reaching overhead, stairs, down hills

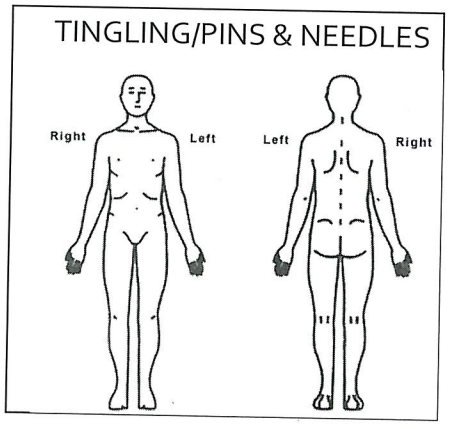
10. LOCATION: Please put x's wherever you feel these:

Sample:









11. Who referred you to Dr. McDevitt?_____