

PENINSULA PAIN CARE

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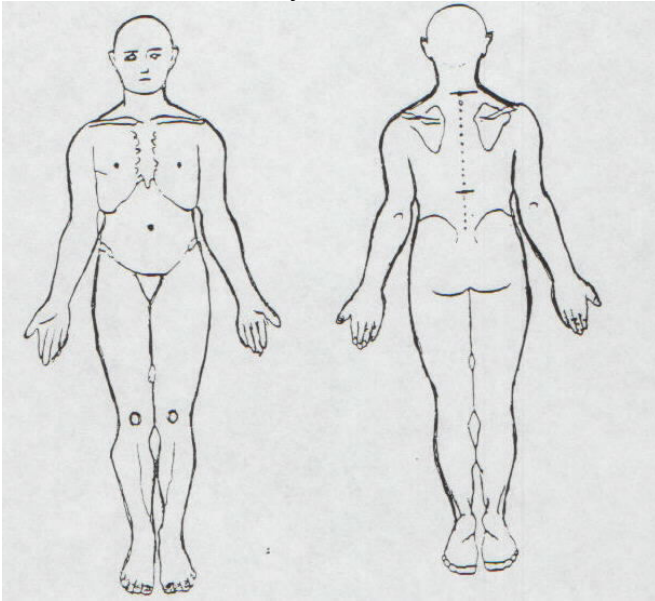
Follow up Pain Questionnaire

Name _____

Date _____

Please tell us in one sentence why you are here (e.g. "My back hurts.")

Please show us where you hurt:



How bad is the pain?

| | | | | | | | | | | |
|---------|---|---|---|---|-----------------------|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| No Pain | | | | | Worst Pain Imaginable | | | | | |

How is your mood:

| | | | | | | | | | | |
|-----------|---|---|---|---|----------|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Excellent | | | | | Terrible | | | | | |

How well do you function:

| | | | | | | | | | | |
|-----------------------|---|---|---|---|--------------------|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Able to do everything | | | | | Unable to Function | | | | | |

Which words describe the pain (please circle)?

Throbbing Aching Sharp Dull Shooting Tingling
Burning Numbness Hot Cold Continuous Intermittent

Have you had any new medications, operations, or allergies? Yes No
If yes, please explain:

Do you have any new medical problems? Yes No
If yes please explain:

Please add any comments, which you feel, would be helpful in treating your condition.

Since your last appointment has there been any change to your address, phone number or insurance information: Yes No
If yes please explain: _____

Your Signature: _____

Office use only

INS. _____