Pain Questionnaire and Past Medical History

When did you start having problems? ____

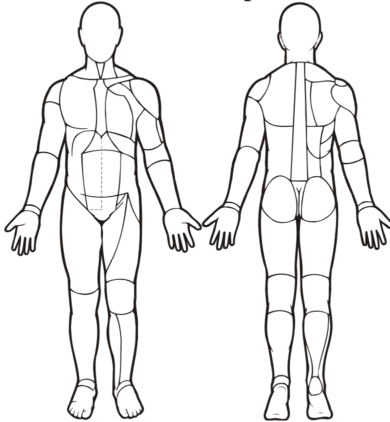
Was an injury or unusual activity involved with the onset of you pain/problem? If so, what?

____

Circle the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable

Location of pain: Mark drawing at pain location and use arrow to show direction of radiation.



0 1 2 3 4 5 6 7 8 9 10

no pain **worst possible pain**

Intensity/Severity: How bad is the pain?

At Present	0-10 scale	____________
At worst (last 24 hrs)	0-10 scale	____________
At Best pain gets	0-10 scale	____________
Acceptable level of pain	0-10 scale	____________

Past Medical History: Please mark all that apply

- □ Cardiac (heart) disorder
- □ Pacemaker/Stent/Defibrillator
- □ Joint Problems/Arthritis
- □ Numbness or Tingling
  - □ Arms
  - □ Hands
  - □ Legs
  - □ Feet
- □ Surgeries (list below)
- □ Bone Disorder/Osteoporosis
- □ Emphysema/COPD
- □ Asthma
- □ Excessive Bleeding/Bruising
- □ Diabetes/Hypoglycemia
- □ Edema
- □ Vision Impairments
- □ Dizziness/Fainting
- □ Hearing Impairment
- □ Depressive Disorder
- □ Allergies to Adhesives (tape)
- □ Latex Allergy
- □ Cancer
- □ Seizures
- □ Stroke
- □ MRSA/Hepatitis
- □ Current Pregnancy

Please describe any of the items checked above:

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Patient Signature: ______________________________________ Date: ________________

REHAB SERVICES PAIN ASSESSMENT

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