The Connecticut Center for Health
Pain Questionnaire

Patient Name:_____ Date: _____

PAIN SECTION *(Only complete this portion if pain is one of your chief complaints)*

List condition(s) in order of importance:	Date you first noticed:	Scale your pain - **"0" is none & "10" is severe**, circle the number None……to……..Severe	Circle the percentage that represents how much of the time you feel pain or your symptom(s) for the listed reason?
1.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%
2.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51 75% 76-100%
3.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%
4.		0 1 2 3 4 5 6 7 8 9 10	0-25% 26-50% 51-75% 76-100%

For each reason or condition listed above, please circle how it happened:

1. *Developed over time. *Illness. *Injury. *Auto accident. *Other_____. *Don't know.
2. *Developed over time. *Illness *Injury. *Auto accident. *Other_____. *Don't know.
3. *Developed over time. *Illness *Injury *Auto accident. *Other_____. *Don't know.
4. *Developed over time. *Illness *injury. *Auto accident. *Other_____. *Don't know.

For each reason or pain condition, please check if it is better or worse with any of the following:

	HEAT		COLD		REST		ACTIVITY		OTHER (describe on line below)	
	better	worse	better	worse	better	worse	better	worse	better	worse
1.	_____	_____	_____	_____	_____	____	_____	_____	_____	
2.	_____	_____	_____	_____	_____	_____	_____	_____	_____	
3.	_____	_____	_____	_____	_____	____	_____	_____	_____	
4.	_____	_____	_____	_____	_____	_____	_____	_____	_____	

Check the box that best describes whether your pain or symptom(s) limit normal activities:

ACTIVITY	**NORMAL**	**SOMEWHAT LIMITED**	**SEVERELY LIMITED**
Lifting			
Bending			
Standing			
Walking			
Sitting			
Climbing stairs			
Running			
Resting in bed			
Intercourse			
Computer work/typing			
Normal work			
Household activities			
Recreational activities			

Other (list below)

Have you had Acupuncture previously? Yes or No What previous treatment have you received for this condition?

_____

_____