Pain Questionnaire

Please describe your current pain complaint:

Please describe your typical daily physical activities (occupational or otherwise):

What is your sleeping position?

What kind of sports do you do (please specify)?

Do you play an instrument (please specify)?

Please describe the event that you think caused your pain (if any):

What movements or activities make your pain worse?

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What can you do to ease your pain?

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How is your sleeping position?

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How long have you had this pain?

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Please indicate (by circling) which term(s) best describe your symptoms:

Aching	Burning	Stabbing	Tender to Touch
Sharp, well defined	Tingling	Shooting	Radiating
Diffuse, poorly defined	Numbness	Cramping	Throbbing

Please indicate (circle) the severity of your pain:

(No Pain) 0-----1------2------3------4------5------6------7------8------9------10 (Severe Pain)

Do you have any other symptoms which concern you, even unrelated to pain?

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Please list all past injuries, accidents (car etc.) and falls (even if you think they are unrelated to your pain)

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Please list all past surgeries (even if you think they are unrelated to your pain)

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Please indicate if applicable:

Are you suffering from high stress?	**Yes** ☐	**No** ☐
Are you often tense?	**Yes** ☐	**No** ☐
Have you ever had to quit any sports or hobbies because of pain / dysfunction?	**Yes** ☐	**No** ☐
Do you have problems with your jaw?	**Yes** ☐	**No** ☐
Do you wear insoles?	**Yes** ☐	**No** ☐