FirstCare Physical Therapy

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Name _____ **Date:** _____

Pain Questionnaire

Please check all that apply. Mark problem areas on diagram below.

□ Aching	□ Exhausting	□ Pressure
□ Burning	□ Gnawing	□ Sharp
□ Continuous	□ Grinding	□ Shooting
□ Crunching	□ Intermittent	□ Squeezing
□ Deep	□ Jabbing	□ Stabbing
□ Disabling	□ Lancinating	□ Superficial
□ Dull	□ Locking	□ Throbbing
□ Dull Throbbing	□ Nagging	□ Tingling
□ Electric Like	□ Numbing	□ Tiring
□ Excruciating	□ Penetrating	□ Unbearable

Do your symptoms affect your sleep? □Yes □No □Somewhat