Pain Disability Questionnaire with Diagram

Name: _____ **Date:** _____ **DOB:** _____ **Occupation:** _____

Complaints: Please write the locations of your symptoms on the lines below. Then circle how often the symptoms occur, when it first began, and write the pain scale.

		Now	Pre-Accident
1.	**Headaches**	Intensity: _____ Frequency: _____	Intensity: _____ Frequency: _____
2.	**Neck Pain**	Intensity: _____ Frequency: _____	Intensity: _____ Frequency: _____
3.	**Arm Pain**	Intensity: _____ Frequency: _____	Intensity: _____ Frequency: _____
4.	**Upper-back Pain**	Intensity: _____ Frequency: _____	Intensity: _____ Frequency: _____
5.	**Mid-back Pain**	Intensity: _____ Frequency: _____	Intensity: _____ Frequency: _____
7.	**Low Back Pain**	Intensity: _____ Frequency: _____	Intensity: _____ Frequency: _____
8.	**Hip / Buttocks**	Intensity: _____ Frequency: _____	Intensity: _____ Frequency: _____
9.	**Leg / Calf**	Intensity: _____ Frequency: _____	Intensity: _____ Frequency: _____
10.	_____	Intensity: _____ Frequency: _____	Intensity: _____ Frequency: _____
11.	_____	Intensity: _____ Frequency: _____	Intensity: _____ Frequency: _____

Circle any of the following that you have noticed any improvement in: (seeing, smelling, breathing, digestion, elimination, or energy levels.)

Intensity Scale:

0 = No Pain
1-3 = Mild Pain
4-6 = Moderate Pain
7-9 = Sever Pain
10 = Hospital Pain

Frequency:

1-2 days/wk
3-4 days/wk
5-7 days/wk