STEINDLER
ORTHOPEDIC CLINIC
Excellence in Motion

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Name: _

Office Use Only: VITALS

Int. _____

Date: _____ Wt_____ Ht_____ BMI_____

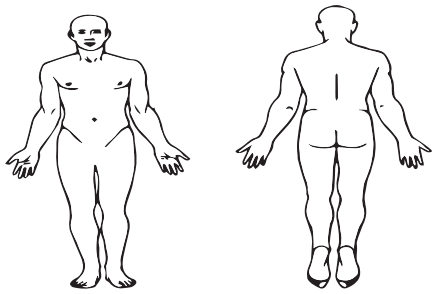
T _____ P _____ R _____ BP _____

1. Throughout our lives, most of us have pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

   Yes No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.

Right Left Left Right



3. Please rate your pain by circling the one number that best describes your pain at its WORST in the last 24 hours.

No Pain **0 1 2 3 4 5 6 7 8 9 10** Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its LEAST in the last 24 hours.

No Pain **0 1 2 3 4 5 6 7 8 9 10** Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on AVERAGE.

No Pain **0 1 2 3 4 5 6 7 8 9 10** Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain your have RIGHT NOW.

No Pain **0 1 2 3 4 5 6 7 8 9 10** Pain as bad as you can imagine

7. What treatments or medications are you receiving for your pain? _____

_____

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much RELIEF you have received.

No Relief **0% 10 20 30 40 50 60 70 80 90 100%** Complete Relief

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9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity

Does not interfere **0 1 2 3 4 5 6 7 8 9 10** Completely Interferes

B. Mood

Does not interfere **0 1 2 3 4 5 6 7 8 9 10** Completely Interferes

C. Walking ability

Does not interfere **0 1 2 3 4 5 6 7 8 9 10** Completely Interferes

D. Normal work (includes both work outside the home and housework)

Does not interfere **0 1 2 3 4 5 6 7 8 9 10** Completely Interferes

E. Relations with other people

Does not interfere **0 1 2 3 4 5 6 7 8 9 10** Completely Interferes

F. Sleep

Does not interfere **0 1 2 3 4 5 6 7 8 9 10** Completely Interferes

G. Enjoyment of life

Does not interfere **0 1 2 3 4 5 6 7 8 9 10** Completely Interferes

What does the pain feel like?
Circle the words that describe your pain.

aching throbbing shooting stabbing squeezing
cramping deep gnawing pricking sharp
tender burning dull radiating exhausting
penetrating nagging numb miserable unbearable

How long have you had this pain? (circle one)

Less than a week 1-2 weeks 2-4 weeks more than a month

What kinds of things make your pain feel better (for example, heat, medicine, rest)? _____

_____

What kinds of things make your pain worse (for example, walking standing, lifting)? _____

_____

Do you have any other symptoms? Circle any that apply

Nausea vomiting constipation diarrhea lack of appetite indigestion
Difficulty sleeping headaches feeling drowsy nightmares dizziness tiredness
itching urinary problems sweating weakness