**Chronic Pain Questionnaire – Chronic (over 8 weeks) Pain in any part of body**

**Chief Complaint:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Onset/Preceding event |  | | | |
| Location |  | | | |
| Duration |  | | | |
| Character/Type |  | | | |
| What makes it better |  | | | |
| What makes it worse |  | | | |
| Severity |  | | | |
| Treatment so far (circle) | Pain medicines | Physical Therapy | Injections/Procedures | Surgery |
| Benefits from treatment |  | | | |
| Sleep habits |  | | | |
| Daily activities |  | | | |

**Additional reasons for my visit:**

**I am hoping to achieve the following goals from my visit:**

**Past medical history:**

|  |  |
| --- | --- |
| Diagnosis | Duration |
|  |  |
|  |  |
|  |  |
|  |  |

**Allergies:**

**Medications:**

|  |  |
| --- | --- |
| Name | Dose |
|  |  |
|  |  |
|  |  |

**Social History:**

|  |  |
| --- | --- |
| Occupation |  |
| Smoking |  |
| Drugs |  |
| Alcohol |  |