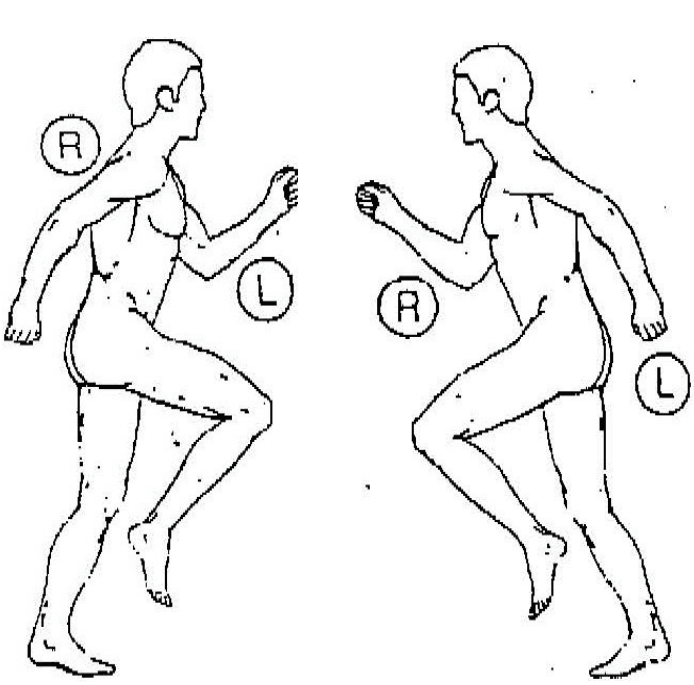
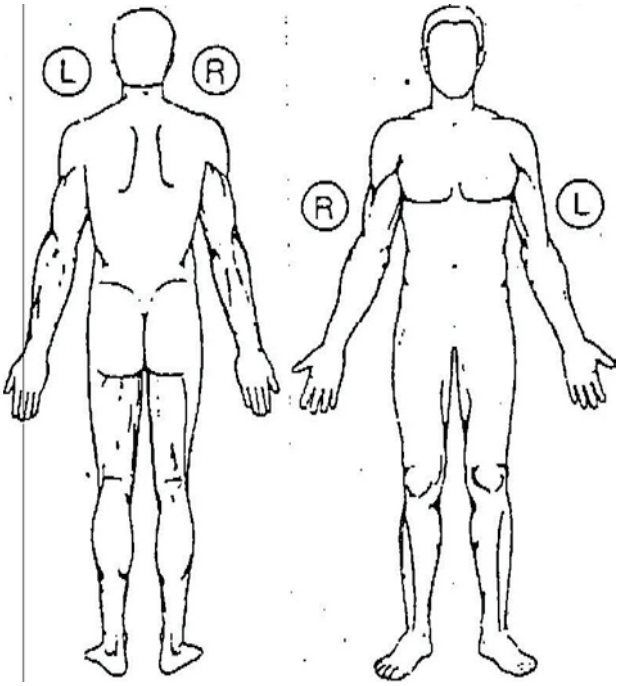
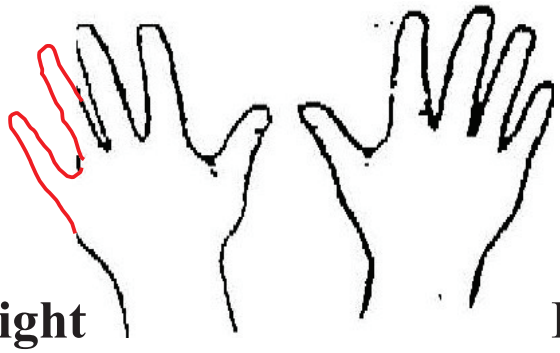
PAIN DIAGRAM

Name: _____ **Date:** _____

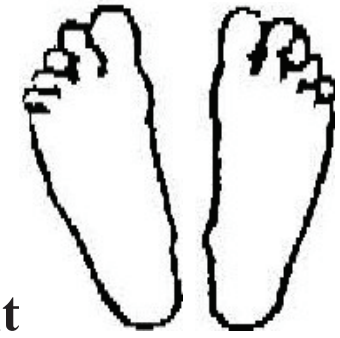
Please indicate ALL areas where you have pain and/or abnormal sensation







Right **Left**

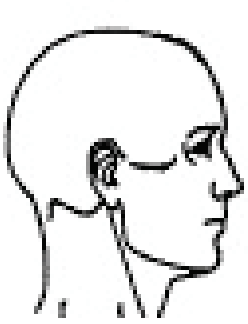


Right **Left**

WORK STATUS: **Temporary total disability** from _____ to _____

Temporary partial disability from _____ to _____

Work restrictions _____



Right

Left

Body part	Avg PAIN level
1	
2	
3	
4	
5	
6	
7	
8	

NOTE: Pain level on an average daily basis for the past week. Range can also be indicated (ex 4-6/10)

Frequency: *Constant-100% Frequent75%-100% Intermittent50%-75% occasional 25%-50% Episodic0-25%*

SHORT-FORM MCGILL PAIN QUESTIONNAIRE-2 (SF-MPQ-2)

Name _____ **Date** _____

Instructions:
This questionnaire provides you with a list of words that describe some of the different qualities of pain and related symptoms. Please **circle the numbers that best describe the intensity of each of the pain** *and* **related symptoms** you felt **ON AVERAGE DURING THE PAST WEEK.**

Intensity: **0= no pain; 10=Worst possible pain.*Use 0 if the word does not describe your pain/related symptoms**

Pain Descriptor	Pain Intensity											Pain Category
1. Throbbing pain	0	1	2	3	4	5	6	7	8	9	10	Continuous Pain
2. Shooting pain	0	1	2	3	4	5	6	7	8	9	10	Intermittent Pain
3. Stabbing pain	0	1	2	3	4	5	6	7	8	9	10	Intermittent Pain
4. Sharp pain	0	1	2	3	4	5	6	7	8	9	10	Intermittent Pain
5. Cramping pain	0	1	2	3	4	5	6	7	8	9	10	Continuous Pain
6. Gnawing pain	0	1	2	3	4	5	6	7	8	9	10	Continuous Pain
7. Hot-burning pain	0	1	2	3	4	5	6	7	8	9	10	Neuropathic Pain
8. Aching pain	0	1	2	3	4	5	6	7	8	9	10	Continuous Pain
9. Heavy pain	0	1	2	3	4	5	6	7	8	9	10	Continuous Pain
10. Tender	0	1	2	3	4	5	6	7	8	9	10	Continuous Pain
11. Splitting pain	0	1	2	3	4	5	6	7	8	9	10	Intermittent Pain
12. Tiring-exhausting	0	1	2	3	4	5	6	7	8	9	10	Affective descriptor
13. Sickening	0	1	2	3	4	5	6	7	8	9	10	Affective descriptor
14. Fearful	0	1	2	3	4	5	6	7	8	9	10	Affective descriptor
15. Punishing-cruel	0	1	2	3	4	5	6	7	8	9	10	Affective descriptor
16. Electro-shock pain	0	1	2	3	4	5	6	7	8	9	10	Intermittent Pain
17. Cold-freezing pain	0	1	2	3	4	5	6	7	8	9	10	Neuropathic Pain
18. Piercing	0	1	2	3	4	5	6	7	8	9	10	Intermittent Pain
19. Pain caused by light touch	0	1	2	3	4	5	6	7	8	9	10	Neuropathic Pain
20. Itching	0	1	2	3	4	5	6	7	8	9	10	Neuropathic Pain
21. Tingling or "pins and needles"	0	1	2	3	4	5	6	7	8	9	10	Neuropathic Pain
22. Numbness	0	1	2	3	4	5	6	7	8	9	10	Neuropathic Pain

NAME _____ **DATE** _____

WORK BEFORE INJURY

Your work demands include (circle yes or no)

DRIVING CARS/TRUCKS/FORKLIFTS AND OTHER EQUIPMENT	Yes	No
WORKING AROUND EQUIPMENT AND MACHINERY	Yes	No
WALKING ON UNEVEN GROUND	Yes	No
EXPOSURE TO EXCESSIVE NOISE	Yes	No
EXPOSURE TO EXTREME TEMPERATURES OR HUMIDITY	Yes	No
EXPOSURE TO DUST, GAS, FUMES, OR CHEMICALS WORKING	Yes	No
AT HEIGHTS	Yes	No
OPERATION OF FOOT CONTROLS OR REPETITIVE FOOT	Yes	No
SPECIAL VISUAL OR AUDITORY PROTECTIVE EQUIPMENT	Yes	No
WORKING WITH BIO-HARZARDS	Yes	No

Your job duties when you were working before the injury

	Never	Occasional	Frequent	Continuous
Climbing				
Balancing				
Stooping				
Bending				
Carrying				
Lifting				
Squatting				
Crawling				
Twisting				
Reaching				
Handling				
Pinching				
Sitting				
Standing				
Walking				
Kneeling				
Keyboarding				

PATIENT ABILITIES TODAY / CURRENT WORK STATUS (circle yes or no)

SECTION II

A. HOW MUCH DOES YOUR PAIN INTERFERE WITH YOUR **ABILITY TO WALK 1 BLOCK**?
0 (does not interfere) 1 2 3 4 5 6 7 8 9 10 (impossible)
B. HOW MUCH DOES YOUR PAIN PREVENT YOU FROM **LIFTING 10 POUNDS**?
0 (does not interfere) 1 2 3 4 5 6 7 8 9 10 (impossible)
C. HOW MUCH DOES YOUR PAIN INTERFERE WITH YOUR **ABILITY TO SIT 1/2 HOUR**?
0 (does not interfere) 1 2 3 4 5 6 7 8 9 10 (impossible)
D. HOW MUCH DOES YOUR PAIN INTERFERE WITH YOUR **ABILITY TO STAND FOR 1/2 HOUR**?

NAME _____ **DATE** _____

0 (does not interfere) 1 2 3 4 5 6 7 8 9 10 (impossible)

E. HOW MUCH DOES YOUR PAIN INTERFERE WITH YOUR **ABILITY TO GET ENOUGH SLEEP**?

0 (does not interfere) 1 2 3 4 5 6 7 8 9 10 (impossible)

F. HOW MUCH DOES YOUR PAIN INTERFERE WITH YOUR **ABITLITY TO PARTICIPATE IN SOCIAL ACTIVITIES?**

0 (does not interfere) 1 2 3 4 5 6 7 8 9 10 (impossible)

Not slightly moderately severely

G. HOW MUCH DOES YOUR PAIN INTERFERE WITH YOUR **ABILITY TO TRAVEL UP TO 1 HOUR** BY CAR?

0 (does not interfere) 1 2 3 4 5 6 7 8 9 10 (impossible)

H. IN GENERAL HOW MUCH DOES YOUR PAIN INTERFERE WITH **YOUR DAILY ACTIVITIES**?

0 (does not interfere) 1 2 3 4 5 6 7 8 9 10 (impossible)

I. HOW MUCH DO YOU LIMIT YOUR ACTIVITIES TO PREVENT YOUR PAIN FROM GETTING WORSE?

0 (does not interfere) 1 2 3 4 5 6 7 8 9 10 (impossible)

J. HOW MUCH DOES YOUR PAIN INTERFERE WITH YOUR **FAMILY/PARTNER**/ SIGNIFICANT OTHER?

0 (does not interfere) 1 2 3 4 5 6 7 8 9 10 (impossible)

K. HOW MUCH DOES YOUR PAIN INTERFERE WITH YOUR **ABILITY TO DO JOBS AROUND YOUR HOME?**

0 (does not interfere) 1 2 3 4 5 6 7 8 9 10 (impossible)

L. HOW MUCH DOES YOUR PAIN INTERFERE WITH YOUR ABILITY TO **SHOWER OR BATHE WITHOUT HELP** FROM SOMEONE ELSE?

0 (does not interfere) 1 2 3 4 5 6 7 8 9 10 (impossible)

Not slightly moderately severely

M. HOW MUCH DOES YOUR PAIN INTERFERE WITH YOUR **ABILITY TO WRITE OR TYPE**?

0 (does not interfere) 1 2 3 4 5 6 7 8 9 10 (impossible)

Not slightly moderately severely

N. HOW MUCH DOES YOUR PAIN INTERFERE WITH YOUR **ABILITY TO DRESS YOURSELF**?

0 (does not interfere) 1 2 3 4 5 6 7 8 9 10 (impossible)

Not slightly moderately severely

O. HOW MUCH DOES YOUR PAIN INTERFERE WITH YOUR ABILITY TO **ENGAGE IN SEXUAL ACTIVITIES?**

0 (does not interfere) 1 2 3 4 5 6 7 8 9 10 (impossible)

Not slightly moderately severely

P. HOW MUCH DOES YOUR PAIN INTERFERE WITH YOUR **ABILITY TO CONCENTRATE**?

0 (does not interfere) 1 2 3 4 5 6 7 8 9 10 (impossible)

NAME _____ **DATE** _____

SECTION III

A. RATE YOUR **OVERALL MOOD** DURING THE LAST WEEK?

0 (good) 1 2 3 4 5 6 7 8 9 10 (bad)

B. DURING THE PAST WEEK, HOW **ANXIOUS** OR WORRIED HAVE YOU BEEN BECAUSE OF YOUR PAIN?

0 (not) 1 2 3 4 5 6 7 8 9 10 (extremely anxious/worried)

C. DURING THE PAST WEEK, HOW **DEPRESSED** HAVE YOU BEEN BECAUSE OF YOUR PAIN?

0 (not) 1 2 3 4 5 6 7 8 9 10 (extremely)

D. DURING THE PAST WEEK, HOW **IRRITABLE** HAVE YOU BEEN BECAUSE OF YOUR PAIN?

0 (not) 1 2 3 4 5 6 7 8 9 10 (extremely)

E. HOW WORRIED ARE YOU ABOUT PREFORMING ACTIVITIES BECAUSE YOUR PAIN/SYMPTOMS MIGHT WORSEN?

0 (not) 1 2 3 4 5 6 7 8 9 10 (extremely)

DO YOU HAVE DIFFICULTY WITH **KEYBOARDING**? Yes No

I need a 10 minute break every (*circle* 1) 10 minutes 15 min 20 min 30 min 45min 60 min

Circle the amount of time you are able to perform this activity **within an 8-hour day**.

½ hour 1 hour 2 hours 4 hours 6 hours 8 hours

DO YOU HAVE DIFFICULTY WITH **FINE MOTOR MANIPULATION**? Yes No

I need a 10 minute break every (*circle* 1) 10 minutes 15 min 20 min 30 min 45min 60 min

Circle the amount of time you are able to perform this activity **within an 8-hour day**.

½ hour 1 hour 2 hours 4 hours 6 hours 8 hours

DO YOU HAVE DIFFICULTY **CLIMBING STAIRS**? Yes No

Can climb: 2 steps 4 steps 10 steps☐must use hand-rails other:

DO YOU HAVE DIFFICULTY **STANDING**? Yes No

Circle the amount of time you are able to perform this activity continuously **at one time:**

½ hour 1 hour 2 hours 4 hours 6 hours 8 hours

Circle the amount of time you have difficulty **within an 8-hour day**.

½ hour 1 hour 2 hours 4 hours 6 hours 8 hours

DO YOU HAVE DIFFICULTY **WALKING**? Yes No

Circle the amount of time you are able to perform this activity continuously **at one time:**

½ hour 1 hour 2 hours 4 hours 6 hours 8 hours

Circle the amount of time you are able to perform this activity **within an 8-hour day**.

½ hour 1 hour 2 hours 4 hours 6 hours 8 hours

DO YOU HAVE DIFFICULTY **SITTING**? Yes No

Circle the amount of time you are able to perform this activity continuously **at one time:**

½ hour 1 hour 2 hours 4 hours 6 hours 8 hours

Circle the amount of time you have difficulty **within an 8-hour day**.

½ hour 1 hour 2 hours 4 hours 6 hours 8 hours

NAME _____ **DATE** _____

Please check to indicate if you are *currently* experiencing any of the following conditions:

☐ Neck Pain/Stiffness
☐ Arm/Hand Pain
☐ Pins/Needles in Arms/hands
☐ Weakness in arms/hands?
☐ Back Pain/Stiffness
☐ Pins/Needles in Legs
☐ Weakness in legs/feet?
☐ Altered gait?

☐ Difficulty speaking
☐ Vision changes ☐ Light Sensitivity
☐ Blurred Vision ☐ Double Vision
☐ Dizziness ☐ Fainting ☐ Headaches
☐ Decreased/attention ☐ Easy irritability
☐ Decreased concentration/multitasking
☐ Altered Taste/Smell ☐ Swallowing difficulty
☐ Bowel/Bladder changes (☐ urgency ☐ incontinence)
☐ Ringing in Ears ☐ Loss of balance ☐ Hearing loss
☐ Using cane or other assistive device?

☐ Leg/Knee Pain ☐Right ☐Left ☐Both
☐ Ankle/foot pain ☐Right ☐Left ☐Both
☐ Swollen calves or feet? ☐Right ☐Left ☐Both ☐ Cold Feet / t o e s

☐ Nervousness ☐ Depression ☐ Anxiety ☐Insomnia ☐ Fatigue
☐ Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea
☐ Fever chills ☐ Cold Sweats ☐ Chest Pain ☐ Shortness of Breath
☐ Stomach Problems ☐Weight Loss ☐Weight gain
☐ Other: _____

_____

PAST HISTORY

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis (A, B, C)	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ Pacemaker	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency		❑ Herniated Disc	❑ Parkinson's Disease
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes (I, II)	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Typhoid Fever
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Ulcers
❑ Bleeding Disorders		❑ Glaucoma	❑ Migraines	❑ Psychiatric Care
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis		❑ Scarlet Fever
❑ Heart Disease	❑ Thyroid Problems	❑ Macular degeneration		❑Fungal Infections

❑ Chron's/ Ulcerative colitis ❑ Lupus ❑ Psoriasis ❑ Skin disorders: Eczema dermatitis
❑ Traumatic brain injury/concussion ❑ PTSD
☐ Other _____

_____

Who is your primary care physician? (doctor and/or practice) _____
Please list any **medications** you are currently taking:

_____

_____

_____

NAME _____ **DATE** _____

Please list any **supplements** you are currently taking (vitamins/herbs/minerals)

_____

_____

Please list any **allergies**: _____

_____

Please list any **surgeries and/or hospitalizations** you have had (type & date): _____

_____

_____

_____

_____

Please list any **injuries, accidents, broken bones** you have had (type & date):

_____

_____

_____

_____

Is there a **family history** of any of the following conditions? (parents, grandparents, siblings)

❑ Heart Disease ❑ Stroke ❑ Diabetes _
❑ Cancer ❑ High bold pressure ❑ Arthritis _
❑ Other (specify)_____

What is your daily/weekly intake of the following:
Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes ____packs/day
Do you exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None
Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor
Do you sleep on your: ❑ Back ❑ Side ❑ Stomach
Do you use a cervical pillow? ❑ Yes ❑ No
Other _____