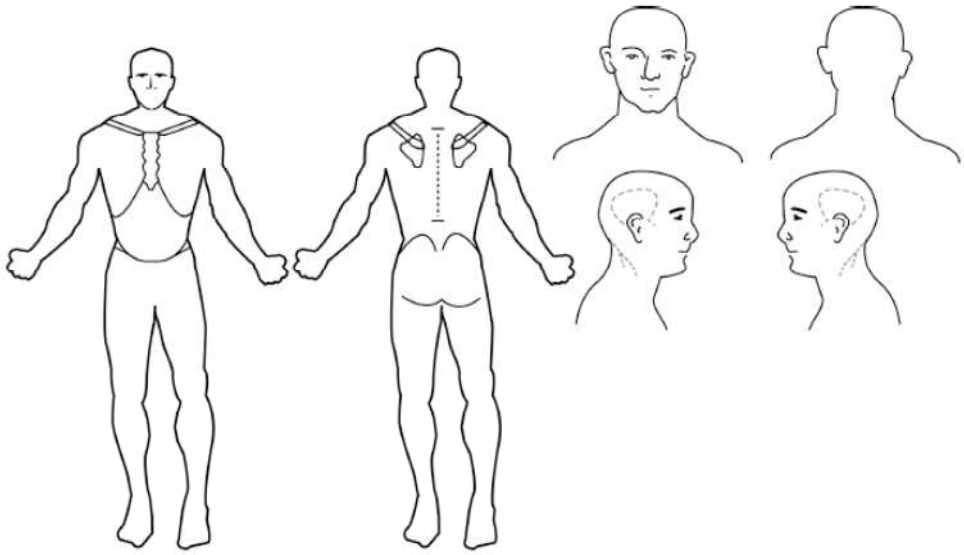
FAST TRACK
Physical Therapy

PAIN QUESTIONNAIRE

Please shade on the diagram below the location of your **current** problem(s)/pain. Please do not mark areas unrelated to your current injury.



Describe your pain:
- ❒ Sharp
- ❒ Dull
- ❒ Aching
- ❒ Shooting
- ❒ Throbbing
- ❒ Stabbing
- ❒ Burning
- ❒ Tingling
- ❒ Other

Is your pain:
- ❒ Constant
- ❒ Intermittent
- ❒ Occasional

Pain Rating: Please rate your pain using the numeric scale listed below.
A rating of "0" means you have no pain at all.
A rating of "10" means that your pain is unbearable and you should go to the Emergency Room immediately.

PLEASE RATE YOUR PAIN AT THE **PRESENT** TIME

0	1	2	3	4	5	6	7	8	9	10
No Pain					Moderate Pain					Intense Pain – Go to ER

PLEASE RATE YOUR PAIN AT ITS WORST IN THE LAST 2 WEEKS

0	1	2	3	4	5	6	7	8	9	10
No Pain					Moderate Pain					Intense Pain – Go to ER

What are your goals for physical therapy? (Check all that apply)

❒ Reduce Pain to ___/10	❒ Increase Function	❒ Improve Posture
❒ Improve Flexibility	❒ Increase Strength	❒ Prevent Surgery
❒ Walk Unassisted	❒ Prepare for Surgery	❒ Return to Full Activities
❒ Increase Stability	❒ Improve Balance	❒ Increase Endurance

❒ Other: _____

What activities are you not performing because of your current problem/pain?

❒ Vacuuming	❒ Making the Beds	❒ Laundry	❒ Golf
❒ Driving	❒ Bathing/Dressing	❒ Cleaning	❒ Dancing
❒ Gardening	❒ Carrying Groceries	❒ Using Hands	❒ Shopping
❒ Cooking	❒ Lifting 10 lbs.	❒ Tennis	❒ Walking Longer Than 1 block

❒ Other: _____

Print Name: _____ Signature: _____ Date: _____