

Does not

interfere

Staying asleep

University of Washington

Completely

interferes

Below is a list of locations of pain. In the first column, please indicate one or more areas where you have felt pain over the past week. In the second column, please indicate the ONE location of your most severe pain:

	LOCATION			(1)		PAIN? AT APPL		WORST I (√ ONE C		
	Head				ALLITA	AIAPPL	1)	(V ONE C	JINL I)	
	Neck									
	Chest									
	Stomac	, h								
	Back	/ 								
	Arm Hand									
	Buttocks									
	Genital/Urinary									
	Leg									
	Knee									
	Foot				l					
Please rate your pain by filling in the circle of the one number that best describes your pain on										
the average in the last week?										
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Falling asleep										
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interfe										interferes
Fill in t interfer O Does r interfer C O Does	he circle ered with al activity of the circle al activity of the circle al activity of the circle of	of the one your:	eek? O 3	O 4 that desc O 4	O 5	O 6	O 7 the past O 7	O 8	0 9	O 10 Pain as bacas you carrimagine O 10 Completely interferes O 10 Completely interferes O 10 Completely interferes

Chronic pain may limit activities that are very important to you (e.g., caring for children, walking, working). We hope your pain treatment will make it easier for you to do these important activities. **Please list one important activity that is difficult for you to perform** so that we can monitor it during your pain treatment.

Activity (d	lescribe):								
How would	l you rate	e the diffi	i culty you	have ha	d doing	this acti	vity over	the pas	st week? C	an
do with O 0 No difficulty	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8		O 10 treme ficulty
Over the p	ast 2 we	eks, have	you bee	n bothere	ed by the	se proble	ms?			
Feeling ne Not being a Feeling do Little intere	able to s wn, depr	ntrol worry hopeless	3	N	ot at all 0 O O O	Severa days 1 O O O		More days than not every days 2 3 O O O O O O O O		
Are you ha	ving any	side eff	ects from	any of th	ne medica	ations yo	u take for	pain?	O Yes C	No No
If yes, wha	t is the n	nost both	ersome si	de effect	:?					
Please circ O 0 None	cle the nu O 1	umber tha O 2	at best sho O 3	ows the s	severity o	of the mo	ost bothe O 7	ersome O 8	O 9	ct: O 10 evere
In the past medication O None	than yo O	ur doctor				l where yo	ou neede	ed to ta	ke more p	oain
Please fill i				ber that b	oest shov	vs how s a	atisfied y	ou are	with the	
0 Extremely Dissatisfied	1	2	3	O 4	O 5	O 6	O 7	O 8		O 10 xtremely Satisfied

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