

WELLINGTON[®]

Orthopaedic & Sports Medicine

Name _____

Therapy Services
Pain Questionnaire

Date _____

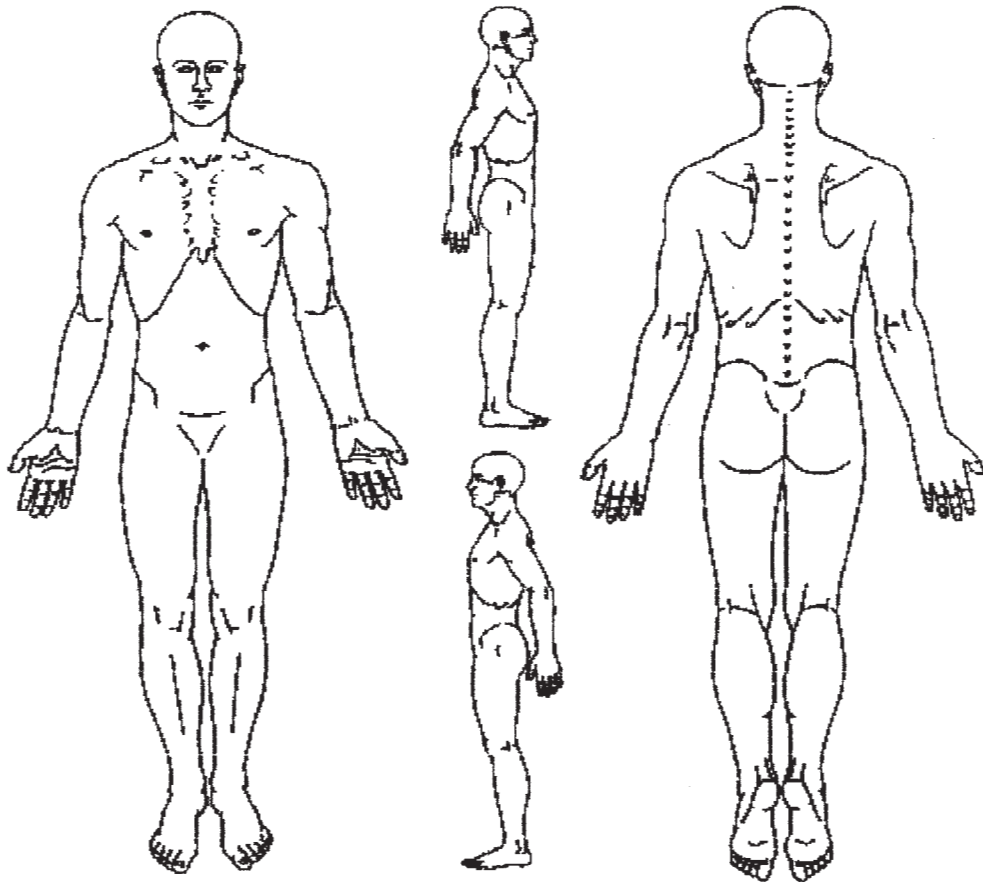
Please report the **highest** level of pain experienced **over the last 24 hours** on a 0-to-10 scale, with 0 representing no pain and 10 the worst pain imaginable.

_____ /10

Please report the **highest** level of pain experienced **over the last 7 days** on a 0-to-10 scale with 0 representing no pain and 10 the worst pain imaginable.

_____ /10

On the diagram below, please indicate where you are experiencing pain or other symptoms, **right now**.



A = ACHE
P = PINS & NEEDLES

B = BURNING
S = STABBING

N = NUMBNESS
O = OTHER