PAIN QUESTIONNAIRE

Name:

SSN: Date:

1) Describe where the pain is located. Does it stay in one location or move to other areas of your body?

2) Describe the pain (for example, burning, dull, sharp, aching) and severity (for example, mild, moderate, severe).

3) How often do you have pain? When does it occur?

4) How long does it last?

5) What activities or circumstances cause or increase the pain.

6) Has the pain limited or restricted your activities? ☐ Yes ☐ No

If yes, explain and provide examples.

7) Does pain affect your ability to think and concentrate? ☐ Yes ☐ No

If yes, explain and provide examples.

List current pain medication(s).

MEDICATION NAME, DOSAGE, AND FREQUENCY	DATE STARTED	IF PRESCRIBED, NAME OF DOCTOR	SIDE EFFECT(S)

8) Do your medication(s) relieve the pain? ☐ Yes ☐ No

9) Describe any other treatments you use to relieve your pain (for example, hot baths, therapy, exercise. How well do they work? How often do you use them?

If you have seen any health care professionals for your pain since you filed your claim, complete the chart below (for example, doctors, pain clinics, rehabilitation centers).

NAME	ADDRESS AND PHONE NUMBER	DATE OF LAST VISIT AND NEXT SCHEDULED APPOINTMENT (IF ANY)

	08-06-2026	
Name of person completing this form (Please print)	Date	Phone

Address	City	State	Zip Code