

# Persistent Pain – Follow-Up Questionnaire

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Please choose the best response to the following questions.

1. How much does your pain interfere with walking?

**Not at all**                      **A little**                      **Moderately**                      **A lot**

2. How much does your pain interfere with enjoying your life (socializing, travel, hobbies, and work)?

**Not at all**                      **A little**                      **Moderately**                      **A lot**

3. How much does your pain interfere with shopping?

**Not at all**                      **A little**                      **Moderately**                      **A lot**

4. How much does your pain interfere with driving?

**Not at all**                      **A little**                      **Moderately**                      **A lot**

5. How much does your pain interfere with your ability to exercise?

**Not at all**                      **A little**                      **Moderately**                      **A lot**

6. How much does your pain interfere with taking a bath?

**Not at all**                      **A little**                      **Moderately**                      **A lot**

7. How much does your pain interfere with getting to the toilet on time?

**Not at all**                      **A little**                      **Moderately**                      **A lot**

8. How much does your pain interfere with your ability to think clearly?

**Not at all**                      **A little**                      **Moderately**                      **A lot**

9. How much does your pain interfere with your sleep?

**Not at all**                      **A little**                      **Moderately**                      **A lot**

10. How much does your pain interfere with your appetite?

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**Not at all                      A little                      Moderately                      A lot**

11. How much does your pain interfere with your mood and spirits?

**Not at all                      A little                      Moderately                      A lot**

12. How much does your pain interfere with your relationships with family and friends?

**Not at all                      A little                      Moderately                      A lot**

13. How much does your pain interfere with your energy?

**Not at all                      A little                      Moderately                      A lot**

***Current  
Medication(s)***

List the current medicines you take for pain and how often you are taking them. You can either say how many and how often, or about how many pills you use in a day for each medicine.

**Name of Medication:**

**Strength & Times per Day:**


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## Review of Symptoms

Have you been bothered by any of the following problems in the past few months? Please describe any problems briefly, with approximate dates. If you need more room, write on the back of the sheet. Leave the line empty if the problem has not occurred.

<b>Problem:</b>	<b>Description, Date(s):</b>
Vision or hearing problem	_____
Lack of energy	_____
Decreased alertness or fatigue	_____
Dizziness or unsteadiness	_____
Passing out spells	_____
Falls or near falls	_____
Dry mouth	_____
Chest pain or discomfort	_____
Reflux or stomach pain	_____
Constipation	_____
Nausea	_____
Change in appetite	_____
Weight change	_____
Swelling	_____
Night sweats	_____
Trouble with sleep	_____
Depression	_____
Trouble with urination	_____
Confusion	_____
Problems having sex	_____