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For each area of pain, check off the specific site(s), then the frequency and intensity of your pain you experience.
(If a pain area does not apply, leave that entire row across blank).

[Pain Area]	[Pain Site]	[Pain Frequency]	[Pain Intensity]
Headaches	❑Left ❑Right ❑Both sides	❑Occasional ❑ Periodic ❑ Constant	❑Mild ❑Moderate ❑Intense
Facial Pain:	❑Left ❑Right ❑Both sides	❑Occasional ❑ Periodic ❑ Constant	❑Mild ❑Moderate ❑Intense
Neck Pain	❑Left ❑Right ❑Both sides	❑Occasional ❑ Periodic ❑ Constant	❑Mild ❑Moderate ❑Intense
Shoulder Pain	❑Left ❑Right ❑Both sides	❑Occasional ❑ Periodic ❑ Constant	❑Mild ❑Moderate ❑Intense
Arm Pain	❑Left ❑Right ❑Both sides	❑Occasional ❑ Periodic ❑ Constant	❑Mild ❑Moderate ❑Intense
Hand Pain	❑Left ❑Right ❑Both sides	❑Occasional ❑ Periodic ❑ Constant	❑Mild ❑Moderate ❑Intense
Stomach Pain	❑Left ❑Right ❑Both sides	❑Occasional ❑ Periodic ❑ Constant	❑Mild ❑Moderate ❑Intense
Chest / Rib Pain	❑Left ❑Right ❑Both sides	❑Occasional ❑ Periodic ❑ Constant	❑Mild ❑Moderate ❑Intense
Upper Back:Pain	❑Left ❑Right ❑Both sides	❑Occasional ❑ Periodic ❑ Constant	❑Mild ❑Moderate ❑Intense
Middle-Back Pain	❑Left ❑Right ❑Both sides	❑Occasional ❑ Periodic ❑ Constant	❑Mild ❑Moderate ❑Intense
Lower Back Pain	❑Left ❑Right ❑Both sides	❑Occasional ❑ Periodic ❑ Constant	❑Mild ❑Moderate ❑Intense
Hip(s) Pain	❑Left ❑Right ❑Both sides	❑Occasional ❑ Periodic ❑ Constant	❑Mild ❑Moderate ❑Intense
Leg(s) Pain	❑Left ❑Right ❑Both sides	❑Occasional ❑ Periodic ❑ Constant	❑Mild ❑Moderate ❑Intense
Foot-Feet Pain	❑Left ❑Right ❑Both sides	❑Occasional ❑ Periodic ❑ Constant	❑Mild ❑Moderate ❑Intense
	❑Left ❑Right ❑Both sides	❑Occasional ❑Periodic ❑Constant	❑Mild ❑Moderate ❑Intense

Rate your current pain-disease related impairment level completing the following activities:
(Use this scale: 0 =-No Limitation → 5 = Moderate Limitation → 10 = Complete Limitation)

____ sitting ____ standing ____ walking ____ lifting ____ sexual life ____ sleeping ____ personal care tasks

____ leisure activities ____ interacting with others ____ manual labor ____ driving ____ concentrating ____ learning

____ reading ____ writing ____ thinking Other activities: ____ _____ ____ _____

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