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PHYSICAL THERAPY
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WATSON PHYSICAL THERAPY
PAIN QUESTIONNAIRE

NAME_____ DATE _____

To help us further evaluate your progress, please mark your present intensity of pain and frequency of symptoms. This form will be used for your benefit and statistical information.

I UNDERSTAND THE ABOVE STATEMENT

SIGNATURE_____

1. Using the **INTENSITY** scale below, rate your symptoms at their best in the past week 0 1 2 3 4 5 6 7 8 9 10
2. Using the **INTENSITY** scale below, rate your symptoms at their worst in the past week 0 1 2 3 4 5 6 7 8 9 10
3. Using the **INTENSITY** scale below, rate your symptoms on average if applicable 0 1 2 3 4 5 6 7 8 9 10

INTENSITY
0 – No pain
1 – Little sore
2 – Sore
3 – Ache
4 – Strong ache
5 – Activity hurts
6 – Almost crying
7 – Crying
8 – Intolerable
9 – Hit head on wall
10 – Jump off bridge

4. Using the **FREQUENCY** scale below, how often are you at your WORST pain? 0 1 2 3 4 5 6 7 8 9 10

FREQUENCY
0 – None
1 – Rare, once/week
2 – 2-3 times/week
3 – Seldom, 3 days/week
4 – 4-7 days
5 – Daily, 3 hours, with movement only
6 – Daily, 3-5 hours
7 – Daily, 5-8 hours
8 – Daily, 8-12 hours
9 – Daily, 12-24 hours
10 – Daily, 24 hours, no sleep

5. Using the **ACTIVITY** scale below, circle number indicating level of activity due to symptoms 0 1 2 3 4 5 6 7 8 9 10

ACTIVITY LEVEL
0 – No restrictions
1,2 – Vigorous activity
3 – Usual and customary
4 – Prolonged walking, standing, driving (1 hour or more)
5 – Moderate walking, standing, driving (30 minutes)
6 – Minimal walking, standing, driving (15 minutes)
7 – Homebound
8 – Restricted, bed and chair
9 – Bed and bathroom only
10 – Bed only