GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (Please Print): _____ DATE: _____

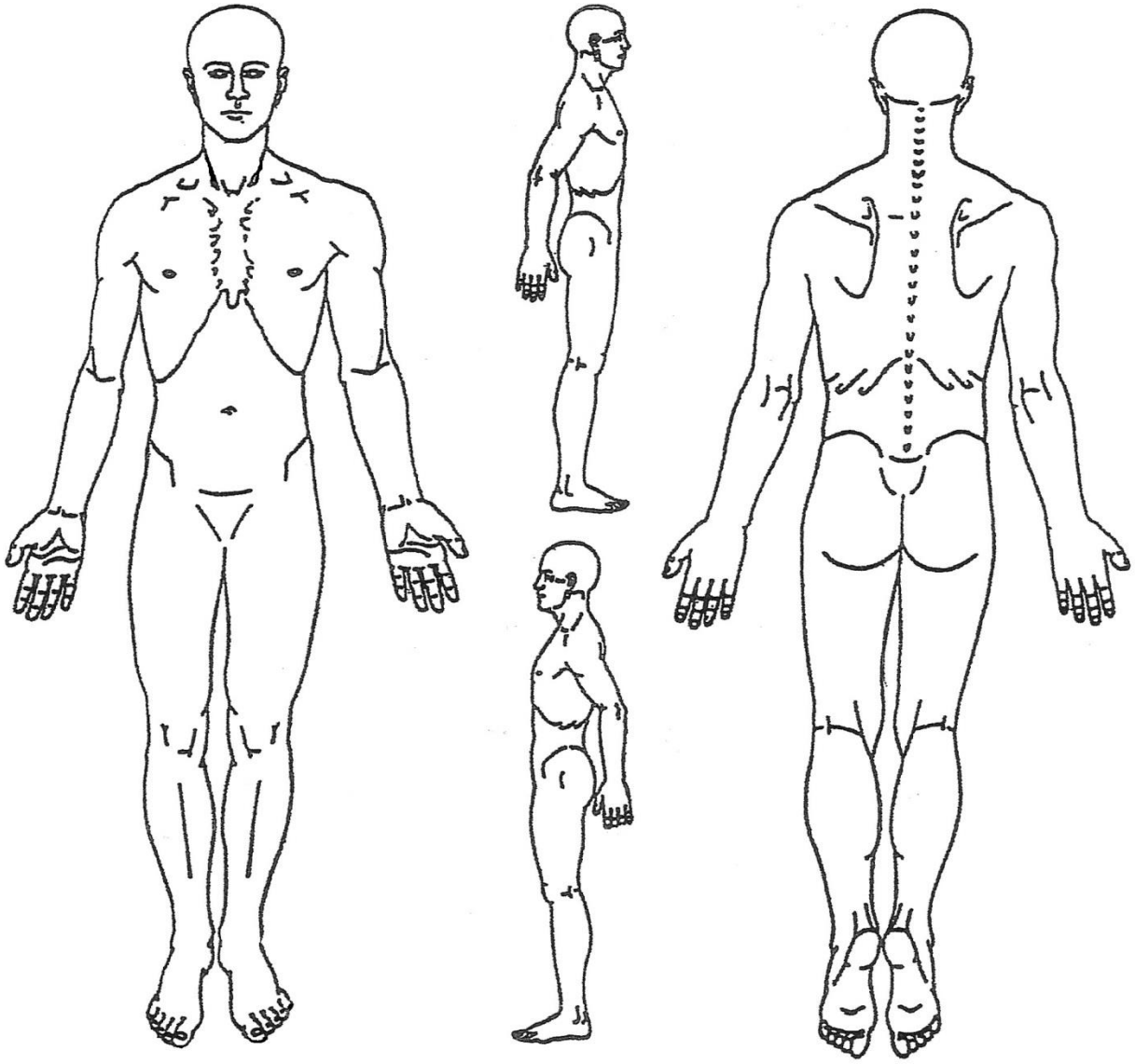
AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____

HOW LONG HAVE YOU HAD THIS PAIN? _____ YRS _____ MONTHS _____ WEEKS

IS THIS YOUR FIRST EPISODE OF THIS PAIN? ____ YES ____ NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

KEY: A= ACHE B= BURNING N= NUMBNESS
O= OTHER S= STABBING P= PINS & NEEDLES



For Doctor's Use:

Chief Complaint: _____