

**PAIN QUESTIONNAIRE**

Date: \_\_\_\_\_ Patient: Last name: \_\_\_\_\_ First name: \_\_\_\_\_

How would you assess your pain **now**, at this moment?

0	1	2	3	4	5	6	7	8	9	10
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none max.

How strong was the **strongest** pain during the past 4 weeks?

0	1	2	3	4	5	6	7	8	9	10
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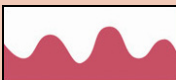
none max.


How strong was the pain during the past 4 weeks **on average**?

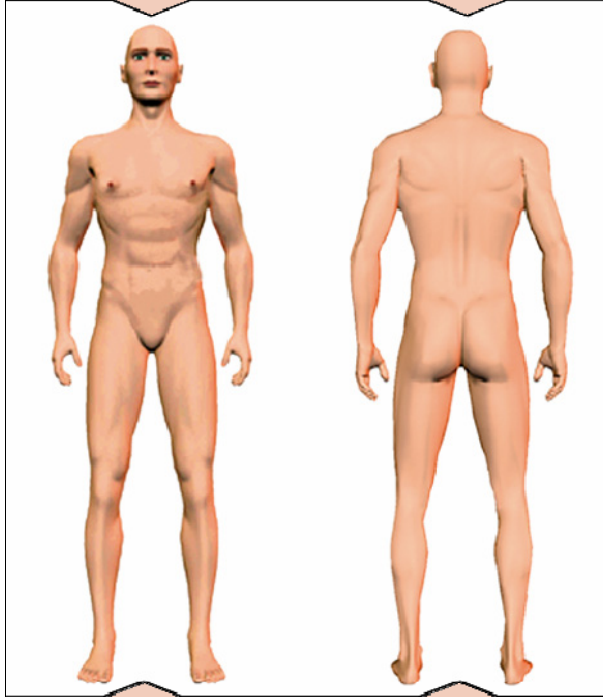
0	1	2	3	4	5	6	7	8	9	10
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none max.

**Mark the picture that best describes the course of your pain:**

	<b>Persistent pain with slight fluctuations</b>	<input type="checkbox"/>
	<b>Persistent pain with pain attacks</b>	<input type="checkbox"/>
	<b>Pain attacks without pain between them</b>	<input type="checkbox"/>
	<b>Pain attacks with pain between them</b>	<input type="checkbox"/>

Please mark with "highlighter"  your **main area of pain**



Does your pain radiate to other regions of your body?    yes     no   
 If yes, please draw the direction in which the pain radiates.

<b>Do you suffer from a burning sensation (e.g., stinging nettles) in the marked areas?</b>					
never <input type="checkbox"/>	hardly noticed <input type="checkbox"/>	slightly <input type="checkbox"/>	moderately <input type="checkbox"/>	strongly <input type="checkbox"/>	very strongly <input type="checkbox"/>
<b>Do you have a tingling or prickling sensation in the area of your pain (like crawling ants or electrical tingling)?</b>					
never <input type="checkbox"/>	hardly noticed <input type="checkbox"/>	slightly <input type="checkbox"/>	moderately <input type="checkbox"/>	strongly <input type="checkbox"/>	very strongly <input type="checkbox"/>
<b>Is light touching (clothing, a blanket) in this area painful?</b>					
never <input type="checkbox"/>	hardly noticed <input type="checkbox"/>	slightly <input type="checkbox"/>	moderately <input type="checkbox"/>	strongly <input type="checkbox"/>	very strongly <input type="checkbox"/>
<b>Do you have sudden pain attacks in the area of your pain, like electric shocks?</b>					
never <input type="checkbox"/>	hardly noticed <input type="checkbox"/>	slightly <input type="checkbox"/>	moderately <input type="checkbox"/>	strongly <input type="checkbox"/>	very strongly <input type="checkbox"/>
<b>Is cold or heat (bath water) in this area occasionally painful?</b>					
never <input type="checkbox"/>	hardly noticed <input type="checkbox"/>	slightly <input type="checkbox"/>	moderately <input type="checkbox"/>	strongly <input type="checkbox"/>	very strongly <input type="checkbox"/>
<b>Do you suffer from a sensation of numbness in the areas that you marked?</b>					
never <input type="checkbox"/>	hardly noticed <input type="checkbox"/>	slightly <input type="checkbox"/>	moderately <input type="checkbox"/>	strongly <input type="checkbox"/>	very strongly <input type="checkbox"/>
<b>Does slight pressure in this area, e.g., with a finger, trigger pain?</b>					
never <input type="checkbox"/>	hardly noticed <input type="checkbox"/>	slightly <input type="checkbox"/>	moderately <input type="checkbox"/>	strongly <input type="checkbox"/>	very strongly <input type="checkbox"/>

(To be filled out by the physician)

never	hardly noticed	slightly	moderately	strongly	very strongly
<input type="checkbox"/> x 0 = <input type="text" value="0"/>	<input type="checkbox"/> x 1 = <input type="text"/>	<input type="checkbox"/> x 2 = <input type="text"/>	<input type="checkbox"/> x 3 = <input type="text"/>	<input type="checkbox"/> x 4 = <input type="text"/>	<input type="checkbox"/> x 5 = <input type="text"/>
<b>Total score <input type="text"/> out of 35</b>					

Date: \_\_\_\_\_ Patient: Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Please transfer the total score from the pain questionnaire:

Total score

Please add up the following numbers, depending on the marked pain behavior pattern and the pain radiation. Then total up the final score:



Persistent pain with slight fluctuations



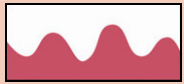
Persistent pain with pain attacks

if marked, or



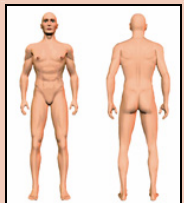
Pain attacks without pain between them

if marked, or



Pain attacks with pain between them

if marked



Radiating pains?

if yes

Final score

## Screening Result

on the presence of a neuropathic pain component



0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38

A neuropathic pain component is unlikely (< 15%)

Result is ambiguous, however a neuropathic pain component can be present

A neuropathic pain component is likely (> 90%)

This sheet does not replace medical diagnostics. It is used for screening the presence of a neuropathic pain component.

