



University of Washington

Below is a list of locations of pain. In the first column, please indicate one or more areas where you have felt pain over the past week. In the second column, please indicate the ONE location of your most severe pain:

LOCATION	ANY PAIN? (√ ALL THAT APPLY)	WORST PAIN? (√ ONE ONLY)
Head		
Neck		
Chest		
Stomach		
Back		
Arm		
Hand		
Buttocks		
Genital/Urinary		
Leg		
Knee		
Foot		

Please rate your pain by filling in the circle of the one number that best describes your pain on the **average** in the last week?

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

Fill in the circle of the one number that describes how, during the past week, **pain has interfered** with your:

General activity

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Enjoyment of life

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Falling asleep

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Staying asleep

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Activity (describe):

○ 0 1 2 3 4 5 6 7 8 9 10
No difficulty Extreme difficulty

	Not at all	Several days	More days than not	Nearly every day
	0	1	2	3
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Little interest or pleasure in doing things	☐	☐	☐	☐

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

0 1 2 3 4 5 6 7 8 9 10

None Severe

○ ○ ○ ○
None 1 - 2 3 - 5 > 5

0 1 2 3 4 5 6 7 8 9 10

Extremely Dissatisfied

Extremely Satisfied