

LOWER EXTREMITY PAIN QUESTIONNAIRE

Patient Name: _____ Date: _____

Please indicate all areas where you are experiencing pain:

Upper Leg (Front / Back / Medial / Lateral) Lower Leg (Front / Back / Medial / Lateral)

Knee (Medial / Lateral) Ankle (Medial / Lateral) Foot (Top / Bottom)

How long have you had pain?

Is your pain rapidly getting worse? Yes / No

Is your pain secondary to major trauma (car accident, fall from height, sports)? Yes / No
If yes, describe in detail:

Is your pain secondary to minor trauma or repetitive stress from work or sports? Yes / No
If yes, describe in detail:

Do you have a history of cancer or blood clots? If Yes, Describe: Yes / No

Have you recently experienced fever, chills or unexplained weight loss? Yes / No

Have you recently experienced a bacterial infection, IV drug use or immune system suppression from corticosteroids, transplant or HIV? Yes / No

Are you experiencing pain that cannot be made to feel worse or better with any specific movement or position? Yes / No

Is your pain associated with other symptoms in your legs (numbness, tingling, burning, etc.)? Yes / No
Describe in detail:

Is your pain associated with difficulty balancing or walking? Yes / No

Is your pain associated with changes in bowel or bladder function? Yes / No

Is your pain induced by coughing, sneezing, straining, or bending forward? Yes / No

Is your pain associated with numbness or tingling in your groin and/or buttocks? Yes / No

What specifically aggravates your pain?

- | | | | |
|---|---------------------------------------|--|---|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Coughing | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> Lying Down | <input type="checkbox"/> Walking | <input type="checkbox"/> Lifting |
| <input type="checkbox"/> Computer Work | <input type="checkbox"/> Driving Car | <input type="checkbox"/> Jumping | <input type="checkbox"/> Stretching |
| <input type="checkbox"/> Bending Forward | <input type="checkbox"/> Bending Back | <input type="checkbox"/> Bending to Left | <input type="checkbox"/> Bending to Right |
| <input type="checkbox"/> Bowel Movements | <input type="checkbox"/> Pushing | <input type="checkbox"/> Running | <input type="checkbox"/> Squatting |
| <input type="checkbox"/> Other, describe: | | | |

What specifically alleviates your pain?

- | | | | | | |
|--|-------------------------------------|------------------------------------|---|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Lying Down | <input type="checkbox"/> Hot Packs | <input type="checkbox"/> Cold Packs | <input type="checkbox"/> Massage | <input type="checkbox"/> Manipulation |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Stretching | <input type="checkbox"/> Traction | <input type="checkbox"/> Electrical Stimulation | <input type="checkbox"/> Ultrasound | |
| <input type="checkbox"/> Medications, describe: | | | | | |
| <input type="checkbox"/> Resting in specific position, describe: | | | | | |
| <input type="checkbox"/> Other, describe: | | | | | |

How would you describe your pain?

- Dull
- Aching
- Burning
- Sharp / Stabbing
- Electrical
- Pins / Needles
- Deep
- Superficial
- Tingling
- Numbing
- Other, describe:

Does your pain spread? Yes / No
 If it spreads, where does it start and where does it go?

If it is pin-point pain, where is it?

On a scale of 1 to 10, 1 being very minimal pain and 10 being the worst pain you can imagine, circle how you would rate your pain:

At its best: 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
 At its worst: 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
 On average: 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

What % of the time do you experience your pain?

Daily: 0%-----25%-----50%-----75%-----100%
 Weekly: 0%-----25%-----50%-----75%-----100%
 Monthly: 0%-----25%-----50%-----75%-----100%

Does your pain interfere with your ability to:

Sleep, describe:

Work, describe:

Exercise, describe:

Other, describe:

At what time of the day is your pain at its worst?

At what time of the day is your pain at its best?

Have you experienced this pain before? Yes / No

History of Previous Evaluations / Treatments for Your Pain

Who have you seen previously for your pain? Describe who, when, diagnosis and treatment previously received:

Have you received any special tests previously for your pain i.e. MRI, X-ray? Describe:

Which previous treatment(s) did you find most beneficial?

Which previous treatment did you find least beneficial?

What do you think is causing your pain?