McGill Pain Assessment Questionnaire

Date:_____

Name: _____Age: _____

Address:_____Phone:_____

MEDICAL HISTORY

A) Year Pain Began:_____

B) Circumstances of Onset:

	Accident at work		Following illness
	Accident at home		Following surgery
	Other accident		Pain "just began"
	Comments:		

C) Present Drug Intake:

Medication	Dose	Frequency	Duration of relief	Amount of relief	Date started
Comments, Side Effects:					

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D) Previous Surgery:

Date	Details

E) Previous Major Illnesses:

Date	Details

F) Previous Physiotherapy/Other Treatments:

Date	Details

G) Doctors and Other Health Professionals Consulted Since Pain Began:

	Allergist		Obst./Gyn.
	Anesthesiologist		Ophthalmologist
	Cardiologist		Orthopaedist
	Dermatologist		Pediatrician
	Ear-Nose-Throat		Plastic Surgeon
	Endocrinologist		Proctologist
	General Practitioner		Psychiatrist
	Internist		Radiologist
	Neurologist		Surgeon (General)

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	Dentist		Chiropractor
	Psychologist		Acupuncturist
	Hypnotist		Clergy
	Osteopath		Faith Healer
	Other/Comments:		

H) Present Program(s) of Treatment (other than drugs):

Psychotherapy Counseling	
Physiotherapy Occupational Therapy	
Surgery	
Other	

PERSONAL HISTORY

A) Marital Status:

	Unmarried		Number of children
	Married		Number of children at home
	Divorced/Separated		Ages of children at home
	Widow/Widower		Number of others at home
	Comments:		

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What Does Your Pain Feel Like?

Some of the words listed below describe your *present* pain. Circle those words that best describe it. Leave out any word group that is not suitable. Use only a single word in each appropriate group—the one that applies *best*.

1	2	3	4
1 Flickering	1 Jumping	1 Pricking	1 Sharp
2 Quivering	2 Flashing	2 Boring	2 Cutting
3 Pulsing	3 Shooting	3 Drilling	3 Lacerating
4 Throbbing		4 Stabbing	
5 Beating		5 Lacerating	
6 Pounding			

5	6	7	8
1 Pinching	1 Tugging	1 Hot	1 Tingling
2 Pressing	2 Pulling	2 Burning	2 Itchy
3 Gnawing	3 Wrenching	3 Scalding	3 Smarting
4 Cramping		4 Searing	4 Stinging
5 Crushing			

9	10	11	12
1 Dull	1 Tender	1 Tiring	1 Sickening
2 Sore	2 Taut	2 Exhausting	2 Suffocating
3 Hurting	3 Rasping		
4 Aching	4 Splitting		
5 Heavy			

13	14	15	16
1 Fearful	1 Punishing	1 Wretched	1 Annoying
2 Frightful	2 Gruelling	2 Blinding	2 Troublesome
3 Terrifying	3 Cruel		
	4 Vicious		
	5 Killing		

17	18	19	20
1 Spreading	1 Tight	1 Cool	1 Nagging
2 Radiating	2 Numb	2 Cold	2 Nauseating
3 Penetrating	3 Drawing	3 Freezing	3 Agonizing
4 Piercing	4 Squeezing		4 Dreadful
	5 Tearing		5 Torturing

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PRESENT PAIN PATTERN:

A) Throughout the Day:

Time	Duration	Time-pattern
Morning		
Afternoon		
Evening		
Night		

B) Body Position: What happens to pain when:

Sitting	
Standing	
Lying	

C) Has your mood (outlook on life, attitudes toward other people, etc.) changed since your pain began? Yes_____ No_____

If yes, how?

D) Accompanying Symptoms:

	Nausea		Constipation
	Headache		Diarrhea
	Dizziness		Menses
	Urination		Other
Comments:			

E) Other Present Illness:

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F) Causes of Increases (+) or Decreases (–) of Pain:
Indicate a "+" or a "–" beside the appropriate cause

	Liquor		Sleep, rest
	Stimulants (coffee, etc.)		Lying down
	Eating		Distraction (TV, etc.)
	Heat		Urination, defecation
	Cold		Tension
	Damp		Bright lights
	Weather changes		Loud noises
	Massage, vibrator		Going to work
	Pressure		Intercourse
	No movement		Mild exercise
	Movement		Fatigue
Comments:			

G) Have you learned ways to relax at moments of tension?
Yes_____No_____

If yes, what methods do you use?

PAIN AND SLEEP:

Condition	Always	Sometimes	Never
Trouble falling asleep			
Medication needed to fall asleep			
Awakened by pain			
Comments:	Average number hours sleep		

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SEXUAL RELATIONS:

	Desire	Ability
Same as before pain		
Somewhat less than before pain		
Very much less than before pain		
None at all		
Comments:		

WORK/ACTIVITY:

A) Type of work (include housework): _____

B) Ability to work at regular job: _____

C) Occasional need to stop all activities because of pain: Yes_____ No _____

D) If "Yes" to C, number of times: Daily:_____ Weekly: _____

E) Comments: _____

EATING HABITS:

A) Has your food intake changed since the onset of pain? Yes _____No _____

Details: _____

B) Do you follow a specific diet? _____

Details: _____

PAIN DESCRIPTION:

A) Choose *one* word group

	Continuous, steady, constant
	Rhythmic, periodic, intermittent
	Brief, momentary, transient

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The following words represent pain of increasing intensity:

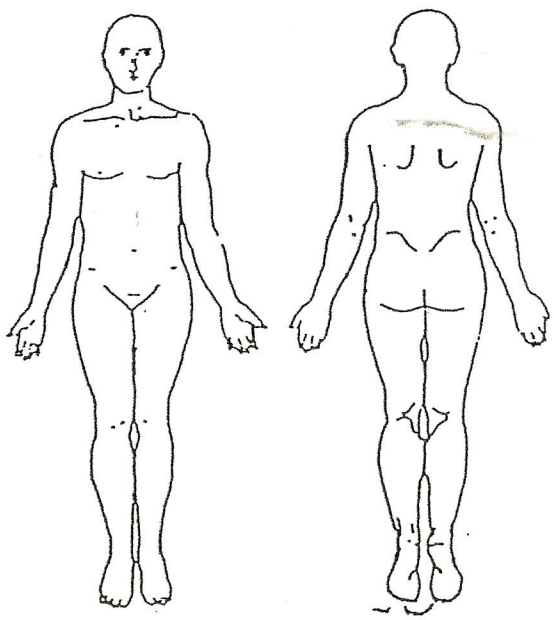
1	2	3	4	5	6
No Pain	Mild	Discomforting	Distressing	Horrible	Excruciating

B) Choose the number of the word which best describes:

	Your pain right now
	Your pain at its worst
	Your pain at its least
	The worst toothache you ever had
	The worst headache you ever had
	The worst stomachache you ever had

INDICATE PAIN LOCATIONS

A) Where does it hurt?



Source: R. Melzack, "The McGill Pain Questionnaire: Major properties and scoring methods," *Pain* 1, 277–299, © R. Melzack.