University Orthopaedic Clinic and Spine Center

PQRS QUESTIONAIRE

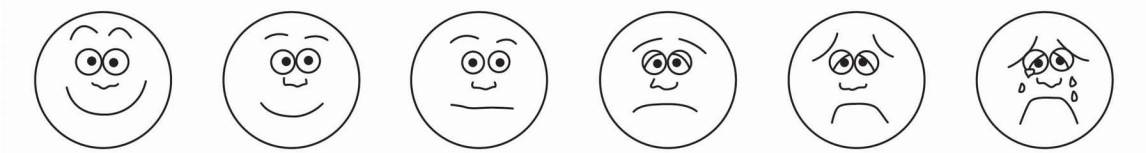
FOR OFFICE USE ONLY

1 2 4 5 6 9 1001 1003 1004 1005 T N AX P F D

Medical Record # _____ **Diagnosis Code** _____

Patient Name _____

What is your pain level today, with 1 being No Pain and 10 being The Worst _____



0	2	4	6	8	10
No Pain	A Little Pain	A Little More Pain	Even More Pain	A Whole Lot Of Pain	Worst Pain

PLEASE USE THE CHART ABOVE TO INDICATE YOUR LEVEL OF PAIN FOR EACH OF THE ITEMS BELOW

1. What is your Overall Daily Pain _____
2. What is your pain during Work/Home Chores _____
3. What is your pain when Bathing/Dressing _____
4. What is your pain furing Sports/Shopping/Church _____
5. What is you pain when Lifting _____
6. What is your pain when Walking _____
7. What is your pain when Driving/Riding _____
8. What is your pain when Sitting _____
9. What is your pain when Standing _____
10. What is your pain when Sleeping _____

UOC STAFF WILL COMPLETE THIS
Functional Assessment Score

_____**/ 100**

Please cricle if you are taking anti-inflammatory or analgesic medications over the counter in the last week:
Aspirin Motrin Tylenol Aleve Advil Other _____

Do you already have an Advance Care Directive ☐ YES ☐ NO

Patient Signature _____ **Date** _____