Pain and symptoms screener (SSS-8)

Full name : _____ Date of birth: _____

Cell phone : _____ e-mail: _____

During the past 7 days, how much have you been bothered by any of the following:

	Not at all	A little bit	Somewhat	Quite a bit	Very much
Stomach or bowel problems	0	1	2	3	4
Back pain	0	1	2	3	4
Pain in your arms, legs or joints	0	1	2	3	4
Headaches	0	1	2	3	4
Chest pain or shortness of breath	0	1	2	3	4
Dizziness	0	1	2	3	4
Feeling tired or having low energy	0	1	2	3	4
Trouble sleeping	0	1	2	3	4

Have any of these lasted for more than 3 months? **YES** **NO**

What activities do you avoid because they are painful or because you are concerned doing them will trigger pain/discomfort?

_____

_____

_____

Are there other pain or bothersome symptoms you would like us to be aware of?

_____

_____

Would you like to learn about care options to reduce or eliminate your pain/symptoms without use of additional medications, injections or surgeries? **YES** **NO**

For office use only

Organization: _____

Practice: _____

Care Provider: _____

Fax to: (877) 720-9491

Phone # for care coordination: _____

Fax # for care coordination: _____

e-mail for care coordination: _____