Lowell Pain Center

Pain and symptoms screener (PHQ-15)

Date: _____

Full Name: _____ Date of birth: _____

Cell phone: _____ E-mail: _____

Provider you are seeing today: _____

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

	Not bothered at all	Bothered a little	Bothered a lot
Stomach pain	0	1	2
Back pain	0	1	2
Pain in your arms, legs or joints (knees, hips, etc)	0	1	2
Menstrual cramps or other problems with your periods *WOMEN ONLY*	0	1	2
Headaches	0	1	2
Chest pain	0	1	2
Dizziness	0	1	2
Fainting spells	0	1	2
Feeling your heart pound or race	0	1	2
Shortness of breath	0	1	2
Pain or problems during sexual intercourse	0	1	2
Constipation, loose bowels, or diarrhea	0	1	2
Nausea, gas, or indigestion	0	1	2
Feeling tired or having low energy	0	1	2
Trouble sleeping	0	1	2

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

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

_____

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

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