

Date: _____ Patient: _____ Last name: _____ First name: _____

How would you assess your pain **now**, at this moment?

0	1	2	3	4	5	6	7	8	9	10
none max.										

How strong was the **strongest** pain during the past 4 weeks?

0	1	2	3	4	5	6	7	8	9	10
none max.										

How strong was the pain during the past 4 weeks **on average**?

0	1	2	3	4	5	6	7	8	9	10
none max.										

Mark the picture that best describes the course of your pain:

	Persistent pain with slight fluctuations	<input type="checkbox"/>
	Persistent pain with pain attacks	<input type="checkbox"/>
	Pain attacks without pain between them	<input type="checkbox"/>
	Pain attacks with pain between them	<input type="checkbox"/>

Please mark your **main area of pain**

Does your pain radiate to other regions of your body? yes no

If yes, please draw the direction in which the pain radiates.

Do you suffer from a burning sensation (e.g., stinging nettles) in the marked areas?

never hardly noticed slightly moderately strongly very strongly

Do you have a tingling or prickling sensation in the area of your pain (like crawling ants or electrical tingling)?

never hardly noticed slightly moderately strongly very strongly

Is light touching (clothing, a blanket) in this area painful?

never hardly noticed slightly moderately strongly very strongly

Do you have sudden pain attacks in the area of your pain, like electric shocks?

never hardly noticed slightly moderately strongly very strongly

Is cold or heat (bath water) in this area occasionally painful?

never hardly noticed slightly moderately strongly very strongly

Do you suffer from a sensation of numbness in the areas that you marked?

never hardly noticed slightly moderately strongly very strongly

Does slight pressure in this area, e.g., with a finger, trigger pain?

never hardly noticed slightly moderately strongly very strongly

(To be filled out by the physician)

never	hardly noticed	slightly	moderately	strongly	very strongly
<input type="checkbox"/> x 0 = 0	<input type="checkbox"/> x 1 = <input type="text"/>	<input type="checkbox"/> x 2 = <input type="text"/>	<input type="checkbox"/> x 3 = <input type="text"/>	<input type="checkbox"/> x 4 = <input type="text"/>	<input type="checkbox"/> x 5 = <input type="text"/>

Total score	out of 35
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Date: _____ Patient: Last name: _____ First name: _____

Please transfer the total score from the pain questionnaire:

Total score

Please add up the following numbers, depending on the marked pain behavior pattern and the pain radiation. Then total up the final score:



Persistent pain with slight fluctuations

0



Persistent pain with pain attacks

- 1

if marked, or



Pain attacks without pain between them

+ 1

if marked, or



Pain attacks with pain between them

+ 1

if marked



Radiating pains?

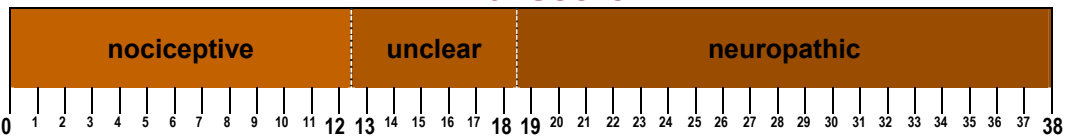
+ 2

if yes

Final score

Screening Result

Final score



A neuropathic pain component is unlikely (< 15%)

Result is ambiguous, however a neuropathic pain component can be present

A neuropathic pain component is likely (> 90%)

This sheet does not replace medical diagnostics. It is used for screening the presence of a neuropathic pain component.

Development/Reference: R. Freynhagen, R. Baron, U. Gockel, T.R. Tölle / Curr Med Res Opin, Vol.22, No. 10 (2006)