Severity of Symptoms: Mark only one:

☐ none: ☐ mild: ☐ moderate: ☐ severe:

Frequency: Mark only one:

☐ never: ☐ constant: ☐ recurring: ☐ intermittent:

Status: Mark only one:

☐ improving: ☐ no change: ☐ worse: ☐ resolved:

Primary Symptom(s) since last visit:

N	Y	
☐	☐	Pain
☐	☐	Stiffness
☐	☐	Functional Limitation
☐	☐	Progression of Deformity
☐	☐	Other

Status since last visit: Mark only one:

☐ Improving ☐ Variable

☐ Worse ☐ Inactive

☐ Stable ☐ Other:

Patient Assessment of Treatment:

☐ Helping Greatly Other:

☐ Helping Some Side Effects: N ☐ Y ☐

☐ Not helping

Locations Affected: ☐ None

	Left	Right	Bilateral		Left	Right	Bilateral		Left	Right	Bilateral
☐ Jaw	☐	☐	☐	☐ Elbow	☐	☐	☐	☐ Ankle	☐	☐	☐
☐ Neck	☐	☐	☐	☐ Wrist	☐	☐	☐	☐ Foot	☐	☐	☐
☐ Shoulder	☐	☐	☐	☐ Hand	☐	☐	☐	☐ Multiple Joints	☐	☐	☐
☐ Mid Back	☐	☐	☐	☐ Hip	☐	☐	☐				
☐ Low Back	☐	☐	☐	☐ Knee	☐	☐	☐				

Have you had any surgeries or new diagnoses since your last visit? ☐ Yes ☐ No

If yes, please list below:

Surgeries: _____

Diagnoses:

_____

Associated Symptoms

01/31/2024

☐ No associated symptoms

Pos	Neg		Pos	Neg		Pos	Neg	
☐	☐	Fever	☐	☐	Skin Lesion(s)	☐	☐	Blood Sugar Issues
☐	☐	Infection	☐	☐	Chest Pain	☐	☐	Muscle Weakness
☐	☐	Fatigue	☐	☐	Cough	☐	☐	Numbness
☐	☐	AM (Morning) Stiffness	☐	☐	Change in Exercise Tolerance	☐	☐	Tingling or Burning Skin
☐	☐	Stiffness After Inactivity	☐	☐	Blood Pressure Issues	☐	☐	Tarry Stools
☐	☐	Eye Symptoms	☐	☐	Edema	☐	☐	Bloody Stools
☐	☐	Change in Vision	☐	☐	Joint Swelling	☐	☐	Jaundice
☐	☐	Dry Eye or Mouth	☐	☐	Abdominal Pain	☐	☐	Rash
☐	☐	Mouth Sores/Lesions	☐	☐	Change in Bowel Habits	☐	☐	Joint Deformity
			☐	☐	Urinary Symptoms	☐	☐	Muscle Stiffness

This questionnaire includes information not available from blood test, x-ray, or any other source other than you. Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can by yourself, if you need help, please ask. There are no right or wrong answers. Please answer exactly as you feel. Thank you.

1. Please place a (x) in the ONE best answer for your abilities at this time:

Over the last week, were you able to:	Without **ANY** Difficulty	With **SOME** Difficulty	With **MUCH** Difficulty	**UNABLE** to do
a. Dress yourself, include tying shoelaces and doing buttons?	☐ 0	☐ 1	☐ 2	☐ 3
b. Get in and out of bed?	☐ 0	☐ 1	☐ 2	☐ 3
c. Lift a full cup or glass to your mouth?	☐ 0	☐ 1	☐ 2	☐ 3
d. Walk outdoors on flat grass?	☐ 0	☐ 1	☐ 2	☐ 3
e. Wash and dry your entire body?	☐ 0	☐ 1	☐ 2	☐ 3
f. Bend down to pick up clothing from the floor?	☐ 0	☐ 1	☐ 2	☐ 3
g. Turn regular faucets on and off?	☐ 0	☐ 1	☐ 2	☐ 3
h. Get in or out car, bus, train, or airplane?	☐ 0	☐ 1	☐ 2	☐ 3
i. Walk two miles or three kilometers if you wish?	☐ 0	☐ 1	☐ 2	☐ 3
j. Participate in recreational activities and sports as you would like, if you wish?	☐ 0	☐ 1	☐ 2	☐ 3
k. Get a good nights sleep?	☐ 0	☐ 1	☐ 2	☐ 3
l. Deal with feeling of anxiety or being nervous?	☐ 0	☐ 1	☐ 2	☐ 3
m. Deal with feelings of depression or feeling blue?	☐ 0	☐ 1	☐ 2	☐ 3

How much pain have you had because of your condition OVER THE PAST WEEK? Please indicate how severe your pain has been:

No Pain ☐ PAIN AS BAD AS IT COULD BE

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

Considering all the ways in which illness and health conditions may affect you at this time, please indicate how you are doing:

VERY WELL ☐ VERY POORLY

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

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Board Certified in Rheumatology
Ricardo Pocurull, MD, PA, CCD , Rajpreet Singh, DO, PA, CCD,
Laura Smith PA-C

Patient Name: _____ Date: _____

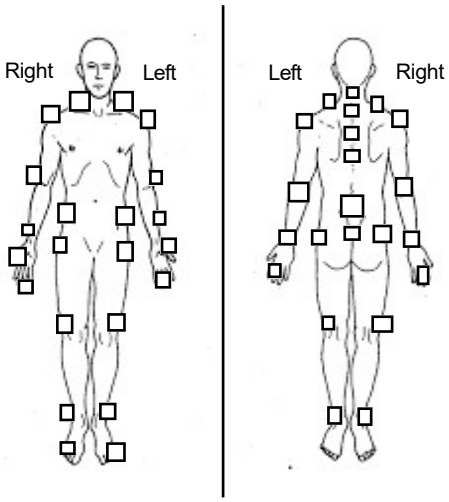
Birth Date: _____

Brief Pain Inventory (Short Form)

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

☐Yes ☐No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by marking the box beside the number that best describes your pain at its **worst** in the last 24 hours.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain — Pain As Bad As You Can Imagine

4. Please rate your pain by marking the box beside the number that best describes your pain at its **least** in the last 24 hours.

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain — Pain As Bad As You Can Imagine

5. Please rate your pain by marking the box beside the number that best describes your pain on the **average.**

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain — Pain As Bad As You Can Imagine

6. Please rate your pain by marking the box beside the number that tells how much pain you have **right now.**

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain — Pain As Bad As You Can Imagine