Bentall Physiotherapy
powered by movement

General Health & Pain Screening Questionnaire

Name: _____ Date: _____

In the past month, how often have you been bothered by feeling down, depressed, or hopeless?

No bother *1 2 3 4 5 6* **7 8 9** *10* **extremely depressed/hopeless**

In the past month, how often have you been bothered by little interest or pleasure in doing things?

No bother *1 2 3 4 5 6* **7 8 9 10 extremely**

Fear & Concern

Do you fear and avoid physical activities as they may harm your condition or worsen you pain?

Yes ____ No ____

Do you feel that there is something wrong with your body?

Yes ____ No ____

Do you feel that people aren't taking your condition seriously enough?

Yes ____ No ____

Do you frequently worry about whether the pain will ever end?

Yes ____ No ____

Stress & Home

Do you feel that you currently have significant stress in your life?

Not stressed *1 2 3 4 5 6* **7 8 9** *10* ***Extremely stressed***

How would you rate your current level of anger in your life?

Not angry *1 2 3 4 5 6* **7 8 9** *10* ***Extremely stressed***

How hopeful are you that you will improve and return to your regular activities in the next 3 months?

Not hopeful **1 2 3 4** *5 6 7 8 9 10* ***Very hopeful***

Work, Hobbies & Exercise

How would you rate your current level of job satisfaction?

I hate my job 1 2 3 4 5 6 7 8 9 10 I absolutely love my job

Do you generally like / get along with your co-workers / your employer / boss?

I hate my workplace 1 2 3 4 5 6 7 8 9 10 I love my workplace

Do you have a regular exercise program that **INCREASE YOUR HEART RATE**?

Yes ____ No ____

Water & Hydration

Do you drink LESS THAN 3 glasses of healthy liquids (water, decaffeinated herbal tea, juice) each day?

Yes ____ No ____

Is your urine dark yellow in colour or has a strong odour?

Yes ____ No ____

Nutrition & Digestion

Do you smoke?

Yes ____ No ____

Do you eat at least 2 servings of **FRESH** fruits & 2 servings of **FRESH** vegetables per day?

Yes ____ No ____

Do you eat less than 3 meals a day?

Yes ____ No _____

Sleep

Do you experience daytime sleepiness?

Yes ____ No ____

Do you know or have been told that you snore during sleep?

Yes ____ No ____

Does your sleeping partner snore?

Yes ____ No ____

Do you get less than 6 hours of sleep regularly?

Yes ____ No ____

Do you have pain at night that wakes you up from sleep?

Yes ____ No ____