

# McGill Short Form Pain Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please read each word below, and decide whether it describes what your pain has felt like over the past week. If a word *does not* describe your pain tick none, and go on to the next item. If a word does describe your pain, then rate how strongly you have by ticking the mild, moderate or severe box.

***In the past week my pain felt like it was***

	None	Mild	Moderate	Severe
1. Throbbing				
2. Shooting				
3. Stabbing				
4. Sharp				
5. Cramping				
6. Gnawing				
7. Hot-burning				
8. Aching				
9. Heavy				
10. Tender				
11. Splitting				
12. Tiring-exhausting				
13. Sickening				
14. Fearful				
15. Punishing-cruel				

Please put a mark on the scale to show how bad your usual pain has been over the past week.

NO PAIN  WORST PAIN

How bad is your pain ***now?***

- 0 NO PAIN \_\_\_\_\_
- 1 MILD \_\_\_\_\_
- 2 DISCOMFORTING \_\_\_\_\_
- 3 DISTRESSING \_\_\_\_\_
- 4 HORRIBLE \_\_\_\_\_
- 5 EXCRUCIATING \_\_\_\_\_