CENTRAL SENSITIZATION INVENTORY (CSI) - PART A

PHYSIOTUTORS

Patient Name: _____

Date: _____

INSTRUCTIONS

Please circle the best response to the right of each statement.

1 I feel tired and unrefreshed when I wake from sleeping.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
2 My muscles feel stiff and achy.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
3 I have anxiety attacks.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
4 I grind or clench my teeth.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
5 I have problems with diarrhea and/or constipation.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
6 I need help in performing my daily activities.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
7 I am sensitive to bright lights.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
8 I get tired very easily when I am physically active.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
9 I feel pain all over my body.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
10 I have headaches.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
11 I feel discomfort in my bladder and/or burning when I urinate.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
12 I do not sleep well.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
13 I have difficulty concentrating.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
14 I have skin problems such as dryness, itchiness, or rashes.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
15 Stress makes my physical symptoms get worse.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
16 I feel sad or depressed.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
17 I have low energy.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
18 I have muscle tension in my neck and shoulders.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
19 I have pain in my jaw.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
20 Certain smells, such as perfumes, make me feel dizzy and nauseated.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
21 I have to urinate frequently.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
22 My legs feel uncomfortable and restless when I am trying to go to sleep at night.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
23 I have difficulty remembering things.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
24 I suffered trauma as a child.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
25 I have pain in my pelvic area.	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**

Total:

CENTRAL SENSITIZATION INVENTORY (CSI) - PART B

PHYSIOTUTORS

Patient Name: _____

Date: _____

INSTRUCTIONS

Have you been diagnosed by a doctor with any of the following disorders?
Please check the box to the right for each diagnosis and write the year of the diagnosis.

	DIAGNOSIS	NO	YES	YEAR DIAGNOSED
1	Restless Leg Syndrome			
2	Chronic Fatigue Syndrome			
3	Fibromyalgia			
4	Temporomandibular Joint Disorder (TMJ)			
5	Migraine or Tension Headaches			
6	Irritable Bowel Syndrome			
7	Multiple Chemical Sensitivities			
8	Neck Injury (including Whiplash)			
9	Anxiety or Panic Attacks			
10	Depression			

MORE INFORMATION