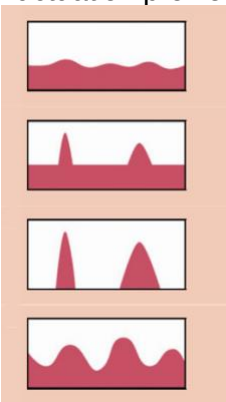
1) In the last 7 days have you experienced any persistent pain or other unusual sensations in your body (e.g. numbness, tingling)

Yes / No

[[If yes, move to the checklist for pain experience:]]

We will now ask you a few questions about your pain experience and about any chronic pain diagnoses you might have.

2) What type of pain do you have (click all that apply)?
   a) Jaw / mouth / facial pain [if a) is checked, display a.-e.]
      a. Duration of pain [slider <1 week - >10 years]
      b. Average intensity of pain in the last 7 days [slider 0=no pain, 10=worst pain]
      c. Frequency (how many days / month) [[slider 0 - 30]]
      d. Mark the picture that best describes the course of your pain [[pain fluctuation profile from PainDETECT]]



Persistent pain with slight fluctuations

Persistent pain with pain attacks

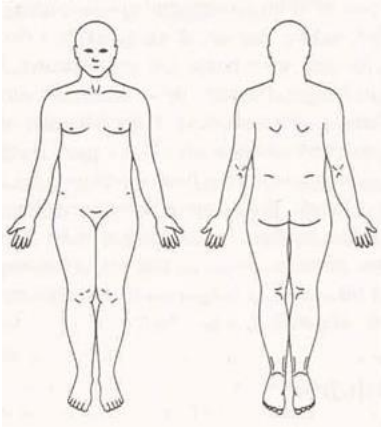
Pain attacks without pain between them

Pain attacks with pain between them

      e. What is the cause of your pain (check all that apply):
         1. Injury
         2. Surgery
         3. Infection
         4. Chronic pain
         5. Other disorder (e.g. diabetes, cancer)
         6. Unknown:
         7. Other cause (please specify) [should be displayed as is, not as branching logic]: _____

   b) Migraine or other headache
      [[questions a.-e.]]

c) Nerve pain (shooting, burning, shock-like pain, e.g. neuropathy, neuralgia)
[[body map: ‘’please mark on the body map below where you feel pain”]]



[[questions a-e]]

d) Joint pain (e.g. knee, hip)
[[Body map, with multiple locations allowed]]
[[questions a-e]]

e) Muscle pain (e.g. shoulder, neck, back)
[[Body map, with multiple locations allowed]]
[[questions a-e]]

f) Chest pain
[[questions a-e]]

g) Epigastric pain (e.g. bloating, gas, heartburn)
[[questions a-e]]

h) Abdominal pain (e.g. frequent or long-lasting stomachache)
[[questions a-e]]

i) Pain in pelvic region (e.g. bladder, vagina, penis, testes)
[[questions a-e]]

j) Excessive fatigue

k) Hypersensitivity to touch (e.g. light touch, wearing clothes)
[[Body map, with multiple locations allowed]]
[[questions a-e]] → *change ‘pain’ to ‘hypersensitivity’*

l) Paresthesia (i.e. tingling, numbness, other unusual sensations)
[[Body map, with multiple locations allowed]]
[[questions a-e]] → *change ‘pain’ to ‘unusual sensations’*

m) Other pain: _____

3) Have you been diagnosed by a medical professional with any of the following conditions related to your pain or unusual sensations (check all that apply)?

a. Temporo-Mandibular Disorder (TMD, TMJD, TMJ)
    i. Year of diagnosis: _____
b. Burning Mouth Syndrome (BMS)
    i. Date of diagnosis: _____
c. Trigeminal Neuralgia
    i. Date of diagnosis: _____
d. Migraine

i. Date of diagnosis: _____

e. Tension-type Headache
   i. Date of diagnosis: _____
f. Other Headache
   i. Date of diagnosis: _____
   ii. Type (e.g cluster headache, sinus headache) : _____
g. Postherpetic Neuralgia
   i. Date of diagnosis: _____
h. Diabetic Neuropathy
   i. Date of diagnosis: _____
i. Other Neuropathy
   i. Date of diagnosis: _____
   ii. Type of neuropathy: _____
j. Back pain
   i. Date of diagnosis: _____
k. Whiplash
   i. Date of diagnosis: _____
l. Arthritis
   i. Date of diagnosis: _____
   ii. Type (e.g. rheumatoid arthritis, osteoarthritis, spondyloarthritis): _____
m. Tendonitis
   i. Date of diagnosis: _____
   ii. Body location: _____
n. Carpal Tunnel Syndrome (CTS)
   i. Date of diagnosis: _____
o. Phantom Limb
   i. Date of diagnosis: _____
   ii. Affected limb: _____
p. Chronic Regional Pain Syndrome (CRPS, RSD)
   i. Date of diagnosis: _____
   ii. Affected limb: _____
q. Pelvic Pain
   i. Date of diagnosis: _____
   ii. Type (Urologic Chronic Pelvic Pain Syndrome (UCPPS), painful bladder syndrome (interstitial cystitis)):_____
r. Somatoform Disorder
   i. Date of diagnosis: _____
s. Irritable Bowel Syndrome (IBS, IBD)
   i. Date of diagnosis: _____
t. (females only) Primary Dysmenorrhea (PMD)
   i. Date of diagnosis: _____
u. (females only) Vulvodynia
   i. Date of diagnosis: _____
v. Fibromyalgia
   i. Date of diagnosis: _____
w. Other (please specify): _____
   i. Date of diagnosis: _____

4) Are you currently taking any medication for your pain?
   a. [If Yes]: please list:_____

5) Are there other sensory experiences that you perceive as painful or extremely unpleasant?
    a. Bright lights or colors
        i. Duration of this symptom [slider <1 week - >10 years]
        ii. Average intensity in the last 7 days [slider 0=no pain, 10=worst pain]
        iii. Frequency (how many days / month do you experience this symptom) [[slider 0 - 30]]
        iv. [[fluctuation profile from PainDETECT]]
        v. Have you received a diagnosis related to this symptom? Yes/No
            1. Diagnosis: _____
            2. Date: _____
    b. Sounds
        [[i– v questions]]
    c. Smells
        [[i– v questions]]
    d. Tastes
        [[i– v questions]]