women's & men's health PHYSIOTHERAPY

Central Sensitisation Inventory: Part A

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 &/ 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 &/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 conditions 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 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 Sensitisation Inventory: Part B

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