

CENTRAL SENSITIZATION INVENTORY: PART A

Name: _____

Date: _____

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: PART B

Name: _____

Date: _____

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.

| | | 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 | | | |