

## CENTRAL SENSITIZATION INVENTORY

(Meyer et al, 2012; Neblett et al 2013)

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