Central Sensitization Inventory

Name:_____ Date:_____

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

	Never	Rarely	Sometimes	Often	Always
1. I feel tired and unrefreshed when I wake from sleeping.	0	1	2	3	4
2. My muscles feel stiff and achy.	0	1	2	3	4
3. I have anxiety attacks.	0	1	2	3	4
4. I grind or clench my teeth.	0	1	2	3	4
5. I have problems with diarrhea and/or constipation.	0	1	2	3	4
6. I need help in performing my daily activities.	0	1	2	3	4
7. I am sensitive to bright lights.	0	1	2	3	4
8. I get tired very easily when I am physically active.	0	1	2	3	4
9. I feel pain all over my body.	0	1	2	3	4
10. I have headaches.	0	1	2	3	4
11. I feel discomfort in my bladder and/or burning when I urinate.	0	1	2	3	4
12. I do not sleep well.	0	1	2	3	4
13. I have difficulty concentrating.	0	1	2	3	4
14. I have skin problems such as dryness, itchiness, or rashes.	0	1	2	3	4
15. Stress makes my physical symptoms get worse.	0	1	2	3	4
16. I feel sad or depressed.	0	1	2	3	4
17. I have low energy.	0	1	2	3	4
18. I have muscle tension in my neck and shoulders.	0	1	2	3	4
19. I have pain in my jaw.	0	1	2	3	4
20. Certain smells, such as perfumes, make me feel dizzy and nauseated.	0	1	2	3	4
21. I have to urinate frequently.	0	1	2	3	4
22. My legs feel uncomfortable and restless when I am trying to go to sleep at night.	0	1	2	3	4
23. I have difficulty remembering things.	0	1	2	3	4
24. I suffered trauma as a child.	0	1	2	3	4
25. I have pain in my pelvic area.	0	1	2	3	4

Total Score: ☐