Pain Questionnaire

Name: Date of birth: Today's date:

The following pages contain information that will help us to best understand your pain and how it impacts your life. This must be filled in and brought to your first appointment (or scan and email or post to us before your appointment) to allow you to receive the excellent care that we can offer. Please use as much detail as possible and be very specific. Use additional paper if needed.

YOUR PAIN HISTORY

How did your pain begin? ◯ Injury at home ◯ Injury at work/school ◯ Injury in another setting ◯ After surgery ◯ Motor vehicle crash ◯ Related to cancer ◯ Related to another illness ◯ No obvious cause ◯ Other

How long has the main pain been present? (Tick one box only)
◯ Less than 3 months ◯ 3 to 12 months ◯ 12 months to 2 years ◯ 2 to 5 years ◯ More than 5 years

When did your pain start? DD: MM: YY:

Tell us the story of your pain: e.g. what started it, how it started, what the sequence of events were until now

The location of your pain:

On the diagram shade in/draw the pains you have, their severity and where it radiates to. Use the key below as a guide. Also add words and descriptions of your pain onto the diagram.

Right Left Left Right

Key:

Pins and needles

Sharp pain (electric shocks)

Broad pain (ache)

YOUR PAIN

Describe your pain(s)

e.g. What does it feel like? Where is your worst pain? Add anything you have not drawn on the diagram.

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Intensity of your pain(s)

	0	1	2	3	4	5	6	7	8	9	10
A. Your pain at its worst in the last week?	0 No pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine
B. Your pain at its least in the last week?	0 No pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine
C. Your pain on average?	0 No pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine
D. How much pain do you have right now?	0 No pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine
	Add your scores to questions A–D:										

During the past week, how much has pain interfered with the following:

	0	1	2	3	4	5	6	7	8	9	10
A. Your general activity?	0 No interference	1	2	3	4	5	6	7	8	9	10 Completely interfered
B. Your mood?	0 No interference	1	2	3	4	5	6	7	8	9	10 Completely interfered
C. Your walking ability?	0 No interference	1	2	3	4	5	6	7	8	9	10 Completely interfered
D. Your normal work (outside the home & housework)?	0 No interference	1	2	3	4	5	6	7	8	9	10 Completely interfered
E. Your relationship with other people?	0 No interference	1	2	3	4	5	6	7	8	9	10 Completely interfered
F. Your sleep?	0 No interference	1	2	3	4	5	6	7	8	9	10 Completely interfered
G. Your enjoyment of life?	0 No interference	1	2	3	4	5	6	7	8	9	10 Completely interfered
	Add your scores to questions A-G:										

Describe four activities that pain limits you from doing and how it affects you:

e.g. cannot do at all, can do but severely limited, can do but moderately limited

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Mark the one picture that best describes the course of your pain through the day:

◯ Persistent pain with slight fluctuations

◯ Persistent pain with pain attacks

◯ Pain attacks without pain between them

◯ Pain attacks with pain between them

NERVE PAIN

Mark one description from each statement that best fits your situation:

A. Do you suffer from a burning sensation (e.g. stinging nettles) in the area of your pain?
◯ Never (0) ◯ Hardly notice (1) ◯ Slightly (2) ◯ Moderately (3) ◯ Strongly (4) ◯ Very strongly (5)

B. Do you have a tingling or prickling sensation in the area of your pain (like crawling ants or electrical tingling)?
◯ Never (0) ◯ Hardly notice (1) ◯ Slightly (2) ◯ Moderately (3) ◯ Strongly (4) ◯ Very strongly (5)

C. Is light touching (clothing, a blanket) in this area painful?
◯ Never (0) ◯ Hardly notice (1) ◯ Slightly (2) ◯ Moderately (3) ◯ Strongly (4) ◯ Very strongly (5)

D. Do you have sudden pain attacks in the area of your pain, like electric shocks?
◯ Never (0) ◯ Hardly notice (1) ◯ Slightly (2) ◯ Moderately (3) ◯ Strongly (4) ◯ Very strongly (5)

E. Is cold or heat (bath water) in this area occasionally painful?
◯ Never (0) ◯ Hardly notice (1) ◯ Slightly (2) ◯ Moderately (3) ◯ Strongly (4) ◯ Very strongly (5)

F. Do you suffer from a sensation of numbness in the areas that you marked?
◯ Never (0) ◯ Hardly notice (1) ◯ Slightly (2) ◯ Moderately (3) ◯ Strongly (4) ◯ Very strongly (5)

G. Does slight pressure in this area, e.g., with a finger, trigger pain?
◯ Never (0) ◯ Hardly notice (1) ◯ Slightly (2) ◯ Moderately (3) ◯ Strongly (4) ◯ Very strongly (5)

Add your scores to questions A–G:

CURRENT PAIN MEDICATIONS

What current treatments or medications are you receiving for your pain?

Pain Medication	Dose	Times per day	Effects / Side effects

In the past 24 hours, how much relief have pain treatments or medications provided?
Please circle the one number that most shows how much relief you have received.

0 1 2 3 4 5 6 7 8 9 10

No pain relief — Complete relief

List the pain medications have you already tried and what the side effects were:

Medications (describe)	What were the effects or side effects

HEALTH CARE

How many times in the past 3 months have you seen a general practitioner in regard to your pain?	Times
How many times in the past 3 months have you seen a medical specialist (e.g. orthopaedic surgeon) in regard to your pain?	Times
How many times in the past 3 months have you seen health professionals other than doctors (e.g. physiotherapist, chiropractor, psychologist) in regard to your pain?	Times
How many times in the past 3 months have you visited a hospital emergency department in regard to your pain? Include all visits regardless of whether or not you were admitted to the hospital from the emergency department	Times
How many times in the past 3 months have you been admitted to hospital as an inpatient because of your pain?	Times
How many diagnostic tests (e.g. X-rays, scans) have you had in the last 3 months relating to your pain?	Times

OTHER PAIN TREATMENT(S)

Injections & blocks (describe)

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What were the effects or side effects

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Surgeries (describe)

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What were the effects or side effects

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Physical Therapy (describe)

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What were the effects or side effects

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Other (describe)

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What were the effects or side effects

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....

ABILITY

Circle one description from each statement that best fits your situation:

I can enjoy things, despite the pain.	0 Not at all	1	2	3	4	5	6 Completely confident
I can do most of the household chores *(e.g. tidying-up, washing dishes, etc.)*, despite the pain.	0 Not at all	1	2	3	4	5	6 Completely confident
I can socialise with my friends or family members as often as I used to do, despite the pain.	0 Not at all	1	2	3	4	5	6 Completely confident
I can cope with my pain in most situations.	0 Not at all	1	2	3	4	5	6 Completely confident
I can do some form of work, despite the pain. ("work" includes housework, paid and unpaid work).	0 Not at all	1	2	3	4	5	6 Completely confident
I can still do many of the things I enjoy doing, such as hobbies or leisure activities, despite the pain.	0 Not at all	1	2	3	4	5	6 Completely confident
I can cope with my pain without medication.	0 Not at all	1	2	3	4	5	6 Completely confident
I can still accomplish most of my goals in life, despite the pain.	0 Not at all	1	2	3	4	5	6 Completely confident
I can live a normal lifestyle, despite the pain.	0 Not at all	1	2	3	4	5	6 Completely confident
I can gradually become more active, despite the pain.	0 Not at all	1	2	3	4	5	6 Completely confident

Add the numbers you have circled:

OTHER MEDICAL HISTORY

Do you have any of the following medical conditions:

◯ Heart disease ◯ High blood pressure ◯ Lung disease ◯ Type 1 diabetes ◯ Type 2 diabetes ◯ Kidney disease
◯ Depression/anxiety ◯ Cancer ◯ Anaemia or other blood disease ◯ Ulcer or stomach disease
◯ Osteoarthritis, degenerative arthritis ◯ Rheumatoid arthritis ◯ Stroke or other neurological condition
◯ Other medical problems (please specify)

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What non-pain medications are you taking? (Include any medications taken for the above conditions.)

Non-pain medication	Dose	Times per day	Effects / Side effects

List any surgeries you have had:

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! List any allergies:

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....

! Do you take anticoagulants? If yes, which medications and doses?:

....

....

SMOKING

Do you or have you ever smoked?

◯ Never

◯ Yes — How many per day: ....

◯ Ex-smoker— Age you quit : ....

WEIGHT

Current weight in KG

....

HEIGHT

Your height in CM

....

ALCOHOL

Do you drink alcohol? ◯ No ◯ Yes

How often? ◯ Daily ◯ Weekly ◯ Monthly or less

How many standard drinks per day do you drink?

◯ 0<2 units/day ◯ 3-6/day ◯ 7+

Glass of wine = 1.5, nip of spirits = 1, 400ml light beer = 1 400ml full strength beer = 1.5 source: http://www.alcohol.gov.au

OTHER

Please answer the questions below using the following scale
0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

How often do you have mood swings? 0 1 2 3 4

How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4

How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4

How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? 0 1 2 3 4

Please elaborate on any illicit drug use, i.e., what have you used, when, and how often?

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How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

SOCIAL

Marital status?

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Whom do you live with?

....

Do you have any family?

....

WORK

Which of the following best describes your current work status? (more than one can be ticked)

◯ Full time paid employment ◯ Part time paid employment ....hrs ◯ Unemployed due to pain
◯ Unemployed (not related to pain) ◯ Retraining ◯ At work — Limited hours and/or duties ◯ Home duties
◯ On leave from work due to pain ◯ Studying (e.g. school, uni) ◯ Retired ◯ Voluntary work

What is your main profession/job/trade?

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If you are not working, what is your source of income?

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Is your visit related to a compensation claim? ◯ Yes ◯ No If yes: ◯ WorkCover ◯ TAC ◯ Other

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Has a compensation claim being initiated? ◯ Yes ◯ No If yes, by whom? ....

Has your claim been settled? ◯ Yes ◯ No If yes, when? ....

MOOD

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

Statement	Rating
I found it hard to wind down	0 1 2 3
I was aware of dryness of my mouth	0 1 2 3
I couldn't seem to experience any positive feeling at all	0 1 2 3
I experienced breathing difficulty (eg, excessively rapid breathing,breathlessness in the absence of physical exertion)	0 1 2 3
I found it difficult to work up the initiative to do things	0 1 2 3
I tended to over-react to situations	0 1 2 3
I experienced trembling (eg, in the hands)	0 1 2 3
I felt that I was using a lot of nervous energy	0 1 2 3
I was worried about situations in which I might panic and make a fool of myself	0 1 2 3
I felt that I had nothing to look forward to	0 1 2 3
I found myself getting agitated	0 1 2 3
I found it difficult to relax	0 1 2 3
I felt down-hearted and blue	0 1 2 3
I was intolerant of anything that kept me from getting on with what I was doing	0 1 2 3
I felt I was close to panic	0 1 2 3
I was unable to become enthusiastic about anything	0 1 2 3
I felt I wasn't worth much as a person	0 1 2 3
I felt that I was rather touchy	0 1 2 3
I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0 1 2 3
I felt scared without any good reason	0 1 2 3
I felt that life was meaningless	0 1 2 3

THOUGHTS AND FEELINGS

Everyone experiences painful situations at some point in their life. Such experiences may include headaches, tooth pain, and joint or muscle pain. People are often exposed to situations that may cause pain, like illness, injury, dental procedures and surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
I worry all the time about whether the pain will end	0	1	2	3	4
I feel I can't go on	0	1	2	3	4
It's terrible and I think it's never going to get any better	0	1	2	3	4
It's awful and I feel it overwhelms me	0	1	2	3	4
I feel I can't stand it anymore	0	1	2	3	4
I become afraid that the pain will get worse	0	1	2	3	4
I keep thinking of other painful events	0	1	2	3	4
I anxiously want the pain to go away	0	1	2	3	4
I can't seem to keep it out of my mind	0	1	2	3	4
I keep thinking about how much it hurts	0	1	2	3	4
I keep thinking about how badly I want the pain to stop	0	1	2	3	4
There's nothing I can do to reduce the intensity of the pain	0	1	2	3	4
I wonder whether something serious may happen	0	1	2	3	4

ADDITIONAL INFORMATION

Please write any additional information that my be relevent:

Pain Specialists Australia
Level 4, 600 Victoria St
Richmond VIC 3121

T 1300 798 682 F 1300 798 385
E reception@painspecialistsaustralia.com.au
W painspecialistsaustralia.com.au