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

When did your pain start? Day: _____ Month: _____ Year: _____

The story of your pain:

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

_____

_____

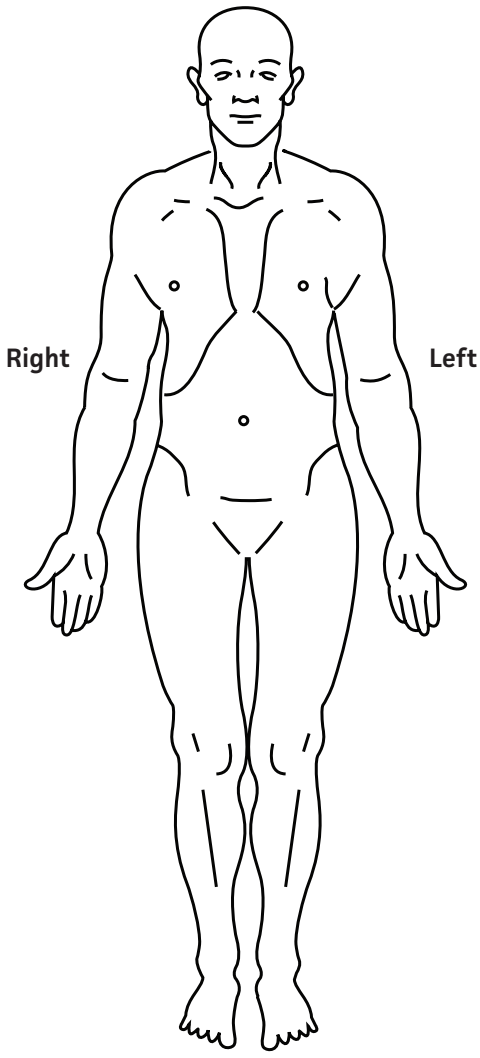
_____

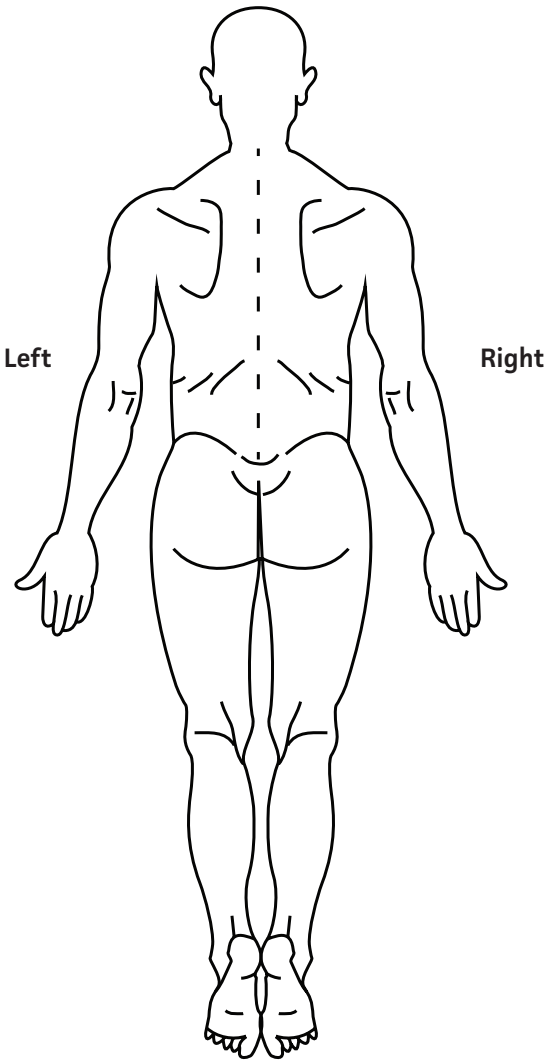
_____

_____

The location of your pain:

On the diagram below 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.





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 any thing extra that you have not written on the diagram

Does your pain radiate (spread)? Y/N

If yes, where does the pain start & where does it radiate to?

What makes your pain worse?

What makes your pain better?

Intensity of your pain(s)

A. *Please rate your pain by circling the one number that best describes your pain at its worst in the past 24 hours.*

0 1 2 3 4 5 6 7 8 9 10

No pain — *Pain as bad as you can imagine*

B. *Please rate your pain by circling the one number that best describes your pain at its least in the past 24 hours.*

0 1 2 3 4 5 6 7 8 9 10

No pain — *Pain as bad as you can imagine*

C. *Please rate your pain by circling the one number that best describes your pain on the average.*

0 1 2 3 4 5 6 7 8 9 10

No pain — *Pain as bad as you can imagine*

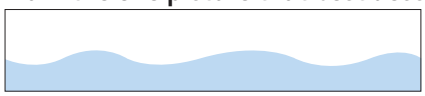
D. *Please rate your pain by circling the one number that tells how much pain you have right now.*

0 1 2 3 4 5 6 7 8 9 10

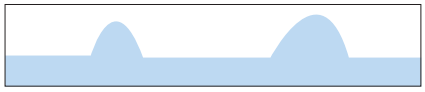
No pain — *Pain as bad as you can imagine*

Add the sum total of questions A –D : ◯

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

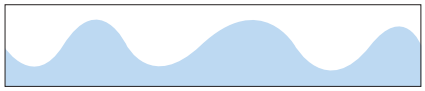


◯ *Persistent pain with slight fluctuations*



◯ *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)

◯ X (0) = _____ ◯ X (1) = _____ ◯ X (2) = _____ ◯ X (3) = _____ ◯ X (4) = _____ ◯ X (5) = _____

Add the sum total of 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 percentage that most shows how much relief you have received.

0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

No pain relief *Complete relief*

OTHER PAIN TREATMENT(S)

List the other pain treatments you have tried and what the effects were:

Medications (describe)	*What were the effects or side effects*
Injections & blocks (describe)	*What were the effects or side effects*
Surgeries (describe)	*What were the effects or side effects*

OTHER PAIN TREATMENT(S)

List the other treatments you have had and what the effects were:

Physical Therapy (describe)	*What were the effects or side effects*
Other (describe)	*What were the effects or side effects*

LIMITATION

When you are in pain, you may find it difficult to do some of the things you normally do. This list contains some sentences that people have used to describe themselves when they have pain. When you read them, you may find that some stand out because they describe your situation today. As you read the list, think of yourself today. When you read a sentence that describes your situation today, put a mark against it. If the sentence does not describe your situation, then leave the space blank and go on to the next one. ***Remember, only mark the sentence if you are sure that it describes your situation today.***

Because of my pain:

- ◯ I am not doing any of the jobs that I usually do around the house because of my pain.
- ◯ I use a handrail to climb stairs because of my pain.
- ◯ I lie down to rest more often than usual because of my pain.
- ◯ I have to hold on to something to get out of an easy chair because of my pain.
- ◯ I ask other people to do things for me because of my pain.
- ◯ I try not to bend or kneel down because of my pain.
- ◯ I get dressed with help from someone else because of my pain.
- ◯ I am more irritable and bad tempered with people than usual.
- ◯ I climb stairs more slowly than usual.
- ◯ I stay at home most of the day because of my pain.
- ◯ I change position frequently to try and get my pain comfortable.
- ◯ I walk more slowly than usual because of my pain.
- ◯ I get dressed more slowly than usual because of my pain.
- ◯ I only stand up for short periods of time because of my pain.
- ◯ I find it difficult to get out of a dining chair because of my pain.
- ◯ I am in pain most of the time.
- ◯ I find it difficult to turn over in bed because of my pain.
- ◯ I do not feel like eating much because of my pain.
- ◯ I have trouble putting on my socks (or stockings) because of my pain.
- ◯ I only walk short distances because of my pain.
- ◯ I sleep less than usual because of my pain.
- ◯ I sit down for most of the day because of my pain.
- ◯ I avoid heavy jobs in the house because of my pain.
- ◯ I stay in bed most of the time because of my pain.

Add the circles you have checked and score in circle : ◯

Describe four activities that pain limits you from doing and how it affects you:
e.g. cannot do at all, can do but severley limited, can do but modererately limited

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

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 activity, despite 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 and sum total in circle :

OTHER MEDICAL HISTORY

List any other medical problems and the medications you take for them:

List any surgeries you have had:

LIST ANY ALLERGIES:

OTHER MEDICAL HISTORY

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

WEIGHT

What is your current weight : _____ kg

SMOKING

Do you or have you ever smoked?

◯ Never ◯ Ex-smoker – Age you quit : _____

ALCOHOL

Do you drink alcohol? ◯ No ◯ Yes

How often? ◯ Daily ◯ Weekly ◯ Monthly or less

How many standard drinks per day do you drink?

◯ O<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 otherthan 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 illicit drug use i.e. What have you used, how often and when?

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

SOCIAL

Marital status?

Who do you live with?

Do you have any family?

WORK

What is your main occupation/job/trade?

Are you currently working? Y/N

If yes, is the work: ◯ normal/full duties ◯ modified duties? How many hours/week do you currently work? _____

WORK

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

Is your visit related to a compensation claim? Y/N

If yes: ◯ WorkCover ◯ TAC ◯ other

Has a compensation claim being initiated? Y/N

If yes, by who?

Has your claim been settled? Y/N

If yes, when?

ADDITIONAL INFORMATION

Please write any additional information that my be relevent:

DASS 21

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

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