ISLAND HEALTH REGIONAL PAIN PROGRAM
PATIENT QUESTIONNAIRE

Please complete the following questionnaire to help us understand your complex pain problem. The information you provide is part of your medical file and, as such, is subject to confidentiality.

☑ ***Please tick appropriate boxes wherever indicated.***

I. PATIENT INFORMATION

Date Questionnaire Completed	
Full Name	
Address: Street / City / Postal Code	
Home Phone #	( )
Cell Phone #	( )
Work Phone #	( ) *May we contact you at work?* ☐ Yes ☐ No
Email address	☐ No ☐ Yes:
Birth Date	*(dd/mm/yyyy)*
Age	
Gender	☐ Male ☐ Female
Family Physician	
BC Care Card #	
Emergency Contact	Name: Phone # ( ) Their relationship to you:
Do you have an open claim related to your pain problem?	✓ Tick all that apply: ☐ WorkSafe BC Claim # _____ ☐ ICBC Claim # _____ ☐ Canada Disability Pension Claim # _____ ☐ Other Claim # _____ ☐ I have not submitted any claims
Are you currently involved in a formal legal suit related to your pain problem?	☐ Yes ☐ No

II. PAIN HISTORY

1. Please describe the pain problem that brings you to this clinic:

   _____

   _____

   _____

   _____

   _____

2. When did your pain first start? Please be as exact as possible.

   Day [ ] Month [ ] Year [ ]

3. How did your pain begin? Check ONE; if more than one applies, check the one that applies the best.

   - ☐ Accident at work
   - ☐ At work, but not involving an accident
   - ☐ Accident at home
   - ☐ Car accident
   - ☐ After surgery
   - ☐ After an illness
   - ☐ Pain just began, no clear reason
   - ☐ Other reasons (please describe) _____

     _____

     _____

III. TREATMENT HISTORY

1. Have you already been assessed by any medical specialists for your pain problem?

☐ No ☐ Yes: Please list:

Name of Specialist	Specialty (if known)	Date of Assessment

2. Have you ever been treated by any of the following disciplines for your pain problem? How helpful was the treatment?

Discipline	Result			When was this treatment?
	Helpful	No change	Un-helpful	
☐ Anesthesiology	☐	☐	☐	
☐ Neurosurgery	☐	☐	☐	
☐ Orthopedic surgery	☐	☐	☐	
☐ Rheumatology	☐	☐	☐	
☐ Psychology	☐	☐	☐	
☐ Psychiatry	☐	☐	☐	
☐ Physiotherapy	☐	☐	☐	
☐ Occupational Therapy	☐	☐	☐	
☐ Chiropractic	☐	☐	☐	
☐ Acupuncture	☐	☐	☐	
☐ Massage Therapy	☐	☐	☐	
☐ Social Worker	☐	☐	☐	
☐ Other Pain Clinic	☐	☐	☐	

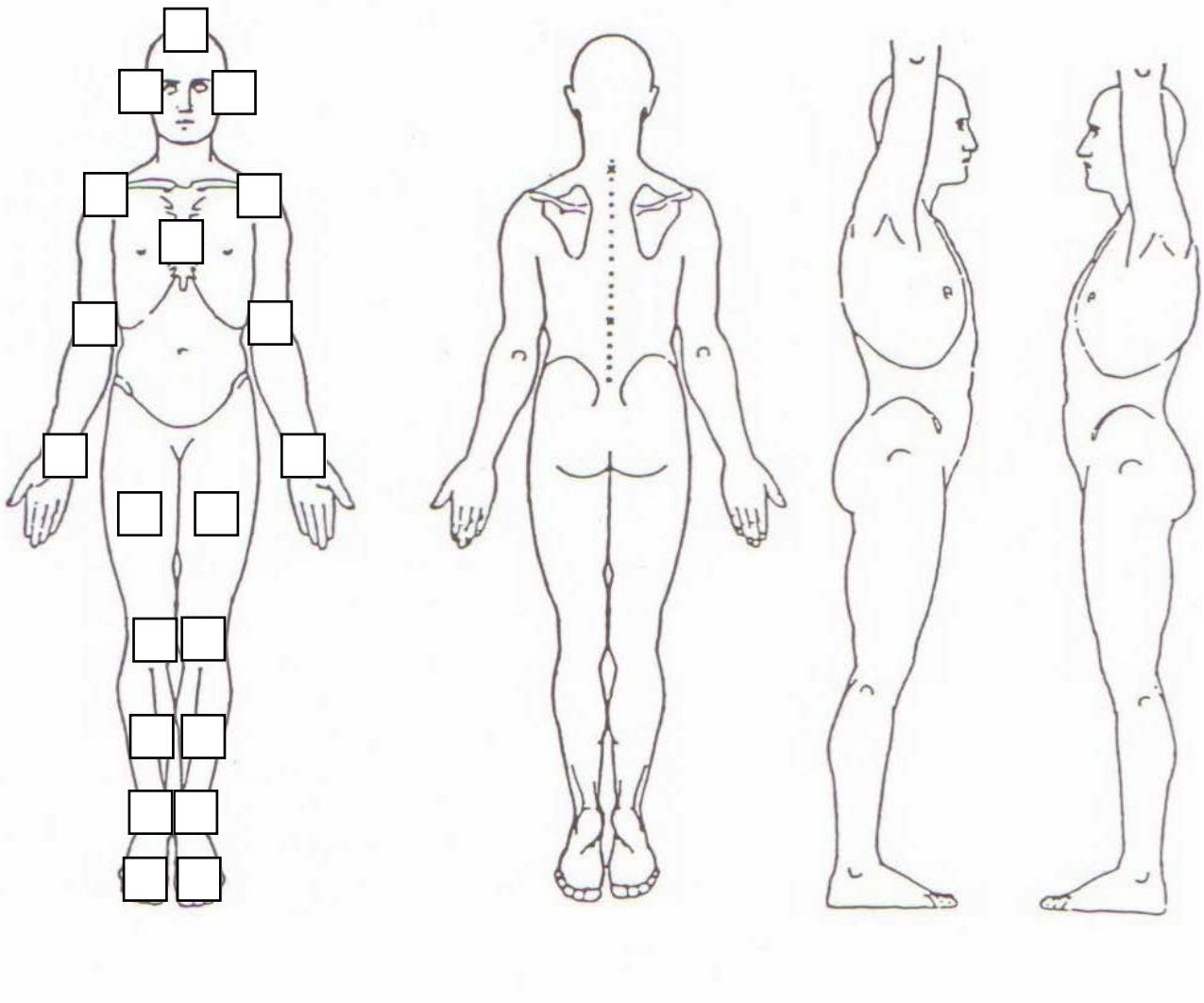
3. Have you had any Medical Imaging done? (i.e. X-ray, CAT scan, MRI, Ultrasound)

☐ No ☐ Yes: Please list:

Type of Image	Where was the image taken?	Date

IV. PAIN DIAGRAM

Please shade or label on the body chart where you currently experience your symptoms.



(If you wish, you may use the symbols in the KEY to describe different sensations.)

KEY	
//////	Ache
sss	Stiffness
xxx	Burning
===	Numbness
ooo	Pins & Needles
www	Swelling

V. CURRENT PAIN

1. How intense is your pain at this moment? (Circle the appropriate number.)

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain

2. What were the highest and lowest levels of your pain in the last week? (Make 2 circles.)

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain

3. What makes your pain worse? (You may check more than one choice.)

☐ Sitting	☐ Bending	☐ Walking	☐ Driving
☐ Standing	☐ Everything	☐ Cold weather	☐ Sex
☐ Lying down	☐ Loud noise	☐ Hot weather	☐ Stress
☐ Lifting	☐ Working	☐ Wet weather	☐ Tension
☐ Household chores	☐ Going up/down stairs	☐ Weather changes	☐ Any movement

☐ Other: _____

4. What makes your pain better? (You may check more than one choice.)

☐ Sitting	☐ Medication	☐ Cold weather	☐ Sex
☐ Standing	☐ Watching TV	☐ Hot weather	☐ Alcohol
☐ Lying down	☐ Working	☐ Pressure	☐ Rest
☐ Stretching	☐ Hot/cold packs	☐ Massage/rubbing	☐ Nothing
☐ Relaxing	☐ Warm/hot bath	☐ Walking	☐ Keeping busy
☐ Reading	☐ Warm/hot shower	☐ Being with others	☐ Keeping my mind off it
☐ Sleeping			

☐ Other: (Describe) _____

5. How long can you comfortably:

Sit _____

Stand _____

Walk _____

Sleep _____

6. How much time during the day do you spend off your feet (lying down, sleeping, watching TV?) _____

7. Sleep:

   (a) During the past month, how often have you had trouble sleeping because of pain?

   ☐ Not during the past month
   ☐ Less than once a week
   ☐ Once or twice a week
   ☐ Three or more times a week

   (b) During the last month, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.)

   Hours Of Sleep/Night _____

   (c) During the past month, how would you rate your overall sleep quality?

   ☐ Very good
   ☐ Fairly good
   ☐ Fairly bad
   ☐ Very bad

8. Associated features:

   If you have pain in your arms or legs, do you have:

   ☐ Increase sweating in the hand or foot?
   ☐ Temperature changes in the hand or foot
   ☐ Colour changes in the hand or foot
   ☐ Swelling in the hand or foot
   ☐ Increased sensitivity to touch in the arm or leg

9. Do you have a history of:

   ☐ Cancer
   ☐ Weight loss in the past 6 months
   ☐ Night sweats/fevers in the past 6 months

VI. IF YOU HAVE LOW BACK PAIN, PLEASE ANSWER THE FOLLOWING QUESTIONS (If not, skip to Section VII.)

1. Have you had back surgery? ☐ Yes ☐ No (If No, please skip to Question 3.)

2. If yes, and you have continued back pain, please answer the following questions:

   (a) What were your symptoms (what were you feeling) before your surgery:

   ☐ Back pain
   ☐ Leg pain: ☐ left ☐ right
   ☐ Back and leg pain

   (b) How long did you wait from the time your back pain began to the time you had your surgery? _____

   (c) Since your back surgery, are you:
   ☐ Better
   ☐ Worse
   ☐ The same

   (d) Date of surgery:
   1st _____ Surgeon _____
   2nd _____ Surgeon _____
   3rd _____ Surgeon _____

3. Which is more painful:

   ☐ Bending forwards
   ☐ Leaning backwards

4. Do you have weakness in your legs? ☐ Yes ☐ No

5. Do you have any bowel or bladder problems? ☐ Yes ☐ No

6. Which is worse? ☐ Back pain ☐ Leg pain ☐ Both are equal

7. **ROLAND MORRIS QUESTIONNAIRE:**

When your back hurts, you may find it difficult to perform many activities throughout the day. Statements listed below have been used by people to describe those times when they are experiencing back pain. As you read them, some may stand out because they describe your pain today.

Please check the boxes next to the statements that best describe your pain today. If the statement does not apply, just leave it blank and move on to the next one.

☐ I stay at home most of the time because of my back.
☐ I change positions frequently to try to get my back comfortable.
☐ I walk more slowly than usual because of my back.
☐ Because of my back, I am not doing any of the jobs that I usually do around the house.
☐ Because of my back, I use a handrail to walk upstairs.
☐ Because of my back, I lie down to rest more often.
☐ Because of my back, I have to hold on to something to get out of my chair.
☐ Because of my back, I try to get other people to do things for me.
☐ I get dressed more slowly than usual because of my back.
☐ I only stand up for short periods of time because of my back.
☐ Because of my back, I try not to bend or kneel down.
☐ I find it difficult to get out of a chair because of my back.
☐ My back is painful almost all the time.
☐ I find it difficult to turn over in bed because of my back.
☐ My appetite is not very good because of my back pain.
☐ I have trouble putting on my socks or stockings because of my back.
☐ I only walk short distances because of my back pain.
☐ I don't sleep well because of my back.
☐ Because of my back pain, I get dressed with help from someone else.
☐ I sit down for most of the day because of my back.
☐ I avoid heavy jobs around the house because of my back.
☐ Because of my back pain, I am more irritable and bad –tempered with people than usual.
☐ Because of my back pain, I walk upstairs more slowly than usual.
☐ I stay in bed most of the time because of my back.

VII. IF YOU HAVE <u>NECK PAIN</u>, PLEASE ANSWER THE FOLLOWING QUESTIONS (If not, skip to Section VIII.)

1. Have you had neck surgery? ☐ Yes ☐ No (If No, please skip to Question 3.)

2. If Yes:

   (a) What were your symptoms (what were you feeling) before your surgery:

   ☐ Neck pain

   ☐ Arm pain: ☐ left ☐ right

   ☐ Neck and arm pain

   (b) How long did you wait from the time your neck pain began to the time you had your surgery? _____

   (c) Since your neck surgery, are you:

   ☐ Better

   ☐ Worse

   ☐ The same

   (d) Date of surgery:

   1st _____ Surgeon _____

   2nd _____ Surgeon _____

   3rd _____ Surgeon _____

3. With respect to your neck pain, which is more painful:

   ☐ Looking up

   ☐ Looking down

   ☐ Looking left

   ☐ Looking right

4. Do you have weakness in your hands/arms? ☐ Yes ☐ No

5. Do you have numbness in your hands/arms? ☐ Yes ☐ No

6. Which is worse: ☐ neck pain ☐ arm pain ☐ both are equal

7. The following questions are designed to help us better understand how your neck pain affects your ability to manage everyday life activities. Please mark in each section, the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present-day situation.

a) Pain intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

b) Personal care

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself, and I am slow and careful.
- ☐ I need some help, but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed. I wash with difficulty and stay in bed.

c) Lifting

- ☐ I can lift heavy weights without causing extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, i.e. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot light or carry anything.

d) Work (occupational and/or personal)

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I can't do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

e) Concentration

- ☐ I can concentrate fully without difficulty.
- ☐ I can concentrate fully with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating.
- ☐ I have a lot of difficulty concentrating.
- ☐ I have a great deal of difficulty concentrating.
- ☐ I can't concentrate at all.

f) Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed for less than 1 hour.
- ☐ My sleep is slightly disturbed for up to 1-2 hours.
- ☐ My sleep is slightly disturbed for up to 2-3 hours.
- ☐ My sleep is slightly disturbed for up to 3-5 hours.
- ☐ My sleep is slightly disturbed for up to 5-7 hours.

g) Driving

- ☐ I can drive my car without neck pain.
- ☐ I can drive as long as I want with slight neck pain.
- ☐ I can drive as long as I want with moderate neck pain.
- ☐ I can't drive as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I can't drive my car at all because of neck pain.

h) Reading

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I can't read as much as I want because of moderate neck pain.
- ☐ I can't read as much as I want because of severe neck pain.
- ☐ I can't read at all because of severe neck pain.

i) Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

j) Recreation

- ☐ I have no neck pain during all recreational activities.
- ☐ I have some neck pain with all recreational activities.
- ☐ I have some neck pain with a few recreational activities.
- ☐ I have neck pain with most recreational activities.
- ☐ I can hardly do recreational activities due to neck pain.
- ☐ I can't do any recreational activities due to neck pain.

VIII. IF YOU HAVE HEADACHES, PLEASE ANSWER THE FOLLOWING QUESTIONS. (If not, skip to Section IX.)

1. Have you seen a neurologist for headaches?

   ☐ No ☐ Yes: (Name)_____

2. What medications are you taking for headaches?

   _____

   _____

3. Do you have any warning signs before your headaches, such as flashing lights, smells, visual problems, increasing neck pain etc.? ☐ Yes ☐ No

   If yes, describe: _____

   _____

4. Do you have associated nausea and/or vomiting? ☐ Yes ☐ No

5. Do noises or bright lights bother you during a headache? ☐ Yes ☐ No

6. How long do your headaches last? _____

7. How often do you get a severe headache? _____

8. What do you do when you have a bad headache? _____

9. Please mark the best response:

   a) I have a headache:

      ☐ 1x per month ☐ 2-4x per month ☐ More than 1x per week

   b) My headaches typically are:

      ☐ Mild ☐ Moderate ☐ Severe

10. The purpose of the following scale* is to identify difficulties that you may be experiencing because of your headache. Please check-off “Yes”, “Sometimes”, or “No” to each item. Answer each question as it pertains to your headache, only.

		Yes	Some-times	No
E1	Because of my headaches I feel handicapped.	☐	☐	☐
F2	Because of my headaches I feel restricted in performing routine daily activities.	☐	☐	☐
E3	No one understands the effect my headaches have on my life.	☐	☐	☐
F4	I restrict recreational activities (sports, hobbies) because of headaches.	☐	☐	☐
E5	My headaches make me angry.	☐	☐	☐
E6	Sometimes I feel I am going to lose control because of my headaches.	☐	☐	☐
F7	Because of my headaches, I am less likely to socialize.	☐	☐	☐
E8	My spouse (significant other) or family and friends have no idea what I'm going through because of my headaches.	☐	☐	☐
E9	My headaches are so bad that I think I am going to go insane.	☐	☐	☐
E10	My outlook on the world is affected by my headaches.	☐	☐	☐
E11	I am afraid to go outside when I feel that a headache is starting.	☐	☐	☐
E12	I feel desperate because of my headaches.	☐	☐	☐
F13	I am concerned that I am paying penalties at work or at home because of my headaches.	☐	☐	☐
E14	My headaches place stress on my relationships with family or friends.	☐	☐	☐
F15	I avoid being around people when I have a headache.	☐	☐	☐
F16	I believe my headaches make it difficult to achieve my goals in life.	☐	☐	☐
F17	I am unable to think clearly because of my headaches.	☐	☐	☐
F18	I get tense (muscle tension) because of my headaches.	☐	☐	☐
F19	I do not enjoy social gatherings because of my headaches.	☐	☐	☐
E20	I feel irritable because of my headaches.	☐	☐	☐
F21	I avoid traveling because of my headaches.	☐	☐	☐
E22	My headaches make me feel confused.	☐	☐	☐
E23	My headaches make me feel frustrated.	☐	☐	☐
F24	I find it difficult to read because of my headaches	☐	☐	☐
F25	I find it difficult to focus my attention away from my headaches and on other things.	☐	☐	☐

*Jackson GP, Ramadan NM, et al. The Henry Ford Hospital headache disability inventory (HDI). Neurology 1994; 44:837-842

IX. EXPECTATIONS

1. Based on your experiences so far, what do you **realistically expect** will happen to your pain in the coming months? (Check one)
   - ☐ My pain will get worse.
   - ☐ My pain will not change.
   - ☐ My pain will be completely relieved or cured.

2. What do you believe is the cause of your pain?

   _____

   _____

3. If your pain could be reduced, but not completely, how much of a reduction would there need to be for you to feel you could live with it? _____%

4. Do you think your pain may be due to a serious disease, which doctors have not found or have not told you about? ☐ Yes ☐ No ☐ Not sure

X. MEDICATIONS

1. Please list any allergies you might have. (Include over the counter and herbal medications.)

   _____

   _____

2. Do you think you need pain medication, or stronger pain medication, than you are currently taking? (Circle the appropriate number.)

1	2	3	4	5
Agree Strongly	Agree	Unsure	Disagree	Disagree Strongly

3. What medications are you **currently** taking for your pain?

Drug Name	Dosage	How often?	Date Started	Side Effects?	Is it Effective?
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No

4. What medications have you **tried in the past** for your pain but have stopped using?

Drug Name	Were there side effects?	Was it effective?
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No

5. What medications do you take for **other health conditions**?

Drug Name	Dosage	How often?	Date Started	Side Effects?	Is it Effective?
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No

6. Opiate History: Opiate (narcotic) medications include: Codeine, Morphine, Hydromorphone (Dilaudid), Oxycodone (Percocet, Endocet), Tramadol (Tramacet), and Fentanyl patch.
   Please ask if you are not sure if your medication is an opiate.

   (a) I AM currently taking OPIATE medication.
   - ☐ Yes: Please answer the following questions.
   - ☐ No: Please skip to Question 7.

   (b) Please tell us about the opiate prescription you are **currently** taking:

Drug Name	How many tablets are in a prescription?	How many days are there between refills?

(c) Do you have any of the following side effects?

- ☐ Nausea
- ☐ Itching
- ☐ Sweating
- ☐ Stomach irritation
- ☐ Constipation
- ☐ Other:
- ☐ Difficulty urinating
- ☐ Intoxication
- ☐ Drowsiness
- ☐ Confusion
- ☐ Loss of sex drive

(d) Which doctor(s) currently prescribes this medication? _____

(e) Which pharmacy dispenses this medication to you?
_____

(f) How long does each prescription usually last?
_____

(g) PLEASE DO NOT BE OFFENDED BY THE FOLLOWING QUESTIONS. THEY ARE ROUTINE QUESTIONS ASKED OF EVERYONE ON OPIATE MEDICATIONS:

	Yes	No
Have you ever sold, or attempted to sell, or give these medications to anyone else?	☐	☐
Have you ever bought, or attempted to buy, any of these medications from anyone other than the pharmacy?	☐	☐
Have you ever been involved in illegal drug use?	☐	☐
Have you ever stolen, forged, or attempted to steal or forge a prescription?	☐	☐
Have you ever injected, smoked, or attempted to inject or smoke any of these medications?	☐	☐
Does your activity increase when you take these medications?	☐	☐
Do you use these medications for anything other than pain relief?	☐	☐

If yes, please explain: _____

_____

_____

7. Drug and Alcohol History:

(a) Do you smoke cigarettes/cigars? ☐ Yes ☐ No

(b) Do you smoke, or have you smoked marijuana? ☐ Yes ☐ No

(c) Do you drink alcohol? ☐ Yes ☐ No

If yes:

1) How many days/week do you drink? _____
2) How many drinks do you have on the days you do drink? _____
3) Do you drink alcohol to relieve your pain? ☐ Yes ☐ No
4) Have you ever tried to cut down? ☐ Yes ☐ No
5) Do you get Angry when people comment on your drinking? ☐ Yes ☐ No
6) Do you feel Guilty about your drinking? ☐ Yes ☐ No
7) Do you ever need an "Eye opener" in the morning? ☐ Yes ☐ No

(d) Have you ever had a problem with drug abuse? ☐ Yes ☐ No

If yes, please give details: _____

_____

_____

(e) Has anyone in your family had a problem with drugs or alcohol? ☐ Yes ☐ No

Explain: _____

_____

_____

XI. PAIN IMPACT

Briefly describe the IMPACT your pain problem has had on you with respect to:

Mood:

_____

_____

_____

_____

Ability to socialize:

_____

_____

_____

_____

Affect on your relationship with your spouse, family, and friends:

_____

_____

_____

_____

How would you describe your quality of life?

_____

_____

_____

_____

XII. OCCUPATION HISTORY

1. What is your usual occupation?

   _____

2. What is your current employment status? ☑ Tick all that apply.

   ☐ Employed full-time
   ☐ Employed part-time
   ☐ Unemployed, not planning on returning to work
   ☐ Unemployed, looking for work
   ☐ Unemployed, disabled
   ☐ Retired, due to pain
   ☐ Retired, not due to pain

3. What is your current source of income? ☑ Tick all that apply.

   ☐ Wage / salary
   ☐ Workers' Compensation
   ☐ Pension
   ☐ Disability benefits
   ☐ Spouse's income
   ☐ Unemployment benefits
   ☐ Social assistance
   ☐ Other:

4. If you are employed, is your work limited due to pain? ☐ Yes ☐ No

5. If you are employed, have you taken time off due to pain in the last year? ☐ Yes ☐ No
   If yes, how much time? _____

6. If you are unemployed now, do you have a job to return to? ☐ Yes ☐ No

7. If you are unemployed now, have you attempted to return to work? ☐ Yes ☐ No

XIII. PSYCHOSOCIAL HISTORY

1. What is your marital status?

   ☐ Married ☐ Common-Law
   ☐ Divorced ☐ Separated
   ☐ Single ☐ Widowed

2. How many children do you have? _____

3. Do you live:

   ☐ Alone ☐ With your spouse and children
   ☐ With children only ☐ With other relatives
   ☐ With spouse ☐ With friends

4. What is your highest level of education?

   ☐ Grade ____ ☐ College
   ☐ University ☐ Other _____

5. Do you know anyone with a chronic pain problem? ☐ Yes ☐ No
   If yes, please describe the nature of their relationship to you:

   _____

   _____

6. Do you have a history of depression, anxiety, or any other psychiatric/psychological problems? ☐ Yes ☐ No
   If yes, is this directly related to your pain problem? ☐ Yes ☐ No

7. Are you currently taking medication for depression or anxiety? ☐ Yes ☐ No

8. Have you ever been suicidal? ☐ Yes ☐ No
   If yes, is this directly related to your pain problem? ☐ Yes ☐ No

XIV. MEDICAL/SURGICAL HISTORY

1. Do you currently have any of the following conditions? ☑ Tick all that apply.

☐ Heart disease
☐ Lung disease
☐ Diabetes
☐ Stroke
☐ Blood clotting problems
☐ Weakness in your arms or legs
☐ Bowel problems
☐ Bladder problems
☐ Weight loss in the past 6 months
☐ Night sweats/fevers in the last 6 months
☐ Cancer If yes, what type?

_____

2. List by year (starting at childhood), as best you can, all illnesses and operations you have had previously.

Year	Surgical Operation (e.g. Back Fusion)	Year	Medical Illness (e.g. Measles, diabetes)

3. What questions would you like answered after your assessment at this pain clinic?

① _____

② _____

③ _____

④ _____

⑤ _____

⑥ _____

PAIN OUTCOMES QUESTIONNAIRE

We ask that **all patients regardless of condition** complete the remainder of the questionnaire.

I. INSTRUCTIONS:

Please circle the number that best describes the question being asked.
Choose only 1 number per question.

1) Enter today's date: _____/_____/_____ (dd/mm/yyyy)

2) On a scale of 0 to 10, with 0 being no pain at all and 10 being the worst possible pain, how would you rate your pain on average during the **past week**?

←											→
No Pain	0	1	2	3	4	5	6	7	8	9	10	**Worst Possible Pain**

3) Does your pain interfere with your ability to walk?

←											→
Not at all	0	1	2	3	4	5	6	7	8	9	10	**All the time**

4) Does your pain interfere with your ability to carry/handle everyday objects such as a bag of groceries or books?

←											→
Not at all	0	1	2	3	4	5	6	7	8	9	10	**All the time**

5) Does your pain interfere with your ability to climb stairs?

←											→
Not at all	0	1	2	3	4	5	6	7	8	9	10	**All the time**

6) Does your pain require you to use a cane, walker, wheelchair, or other devices?

←											→
Not at all	0	1	2	3	4	5	6	7	8	9	10	**All the time**

7) Does your pain interfere with your ability to bathe yourself?

←											→
Not at all	0	1	2	3	4	5	6	7	8	9	10	**All the time**

8) Does your pain interfere with your ability to dress yourself?

←											→
Not at all	0	1	2	3	4	5	6	7	8	9	10	**All the time**

9) Does your pain interfere with your ability to use the bathroom?

←											→
Not at all	0	1	2	3	4	5	6	7	8	9	10	**All the time**

10) Does your pain interfere with your ability to manage your personal grooming (for example, combing your hair, brushing your teeth, etc.)?

←											→
Not at all	0	1	2	3	4	5	6	7	8	9	10	**All the time**

11) Does your pain affect your self-esteem or self-worth?

←											→
Not at all	0	1	2	3	4	5	6	7	8	9	10	**All the time**

12) How would you rate your physical activity?

←											→
Significant limitation in basic activities	0	1	2	3	4	5	6	7	8	9	10	**Can perform vigorous activities without limitation**

13) How would you rate your overall energy?

←											→
Totally worn out	0	1	2	3	4	5	6	7	8	9	10	**Most energy ever**

14) How would you rate your strength and endurance **today?**

←											→
Very poor	0	1	2	3	4	5	6	7	8	9	10	**Very high**

15) How would you rate your feelings of depression **today?**

←											→
Not at all depressed	0	1	2	3	4	5	6	7	8	9	10	**Extremely depressed**

16) How would you rate your feelings of anxiety **today?**

←											→
Not at all anxious	0	1	2	3	4	5	6	7	8	9	10	**Extremely anxious**

17) How much do you worry about re-injuring yourself if you are more active?

←											→
Not at all	0	1	2	3	4	5	6	7	8	9	10	**All the time**

18) How safe do you think it is for you to exercise?

←											→
Not safe at all	0	1	2	3	4	5	6	7	8	9	10	**Extremely safe**

19) Do you have problems concentrating on things **today?**

←											→
Not at all	0	1	2	3	4	5	6	7	8	9	10	**All the time**

20) How often do you feel tense?

←											→
Not at all	0	1	2	3	4	5	6	7	8	9	10	**All the time**

II. PATIENT SPECIFIC FUNCTIONAL SCALE

Step 1: Pick one to three activities that are important to you, which you cannot perform, or have difficulty doing now as a result of your pain.

Step 2: Please circle one number that best rates your ability to perform the activity now.

Activity 1:
0 1 2 3 4 5 6 7 8 9 1 0 Unable To Perform Activity — Able to Perform Activity at Pre-problem Level

Activity 2:
0 1 2 3 4 5 6 7 8 9 1 0 Unable To Perform Activity — Able to Perform Activity at Pre-problem Level

Activity 3:
0 1 2 3 4 5 6 7 8 9 1 0 Unable To Perform Activity — Able to Perform Activity at Pre-problem Level

III. PASS – 20

Individuals who experience pain develop different ways to respond to that pain. We would like to know what you do and what you think about when in pain. Please use the rating scale below to indicate how often you engage in each of the following thoughts or activities.

Circle one number from 0 (NEVER) to 5 (ALWAYS) for each item.

		NEVER					ALWAYS
1.	I think that if my pain gets too severe, it will never decrease.	0	1	2	3	4	5
2.	When I feel pain, I am afraid that something terrible will happen.	0	1	2	3	4	5
3.	I go immediately to bed when I feel severe pain.	0	1	2	3	4	5
4.	I begin trembling when engaged in activity that increases pain.	0	1	2	3	4	5
5.	I can't think straight when I am in pain.	0	1	2	3	4	5
6.	I will stop any activity as soon as I sense pain coming on.	0	1	2	3	4	5
7.	Pain seems to cause my heart to pound or race.	0	1	2	3	4	5
8.	As soon as pain comes on, I take medication to reduce it.	0	1	2	3	4	5
9.	When I feel pain, I think that I may be seriously ill.	0	1	2	3	4	5
10.	During painful episodes, it is difficult for me to think of anything else besides the pain.	0	1	2	3	4	5
11.	I avoid important activities when I hurt.	0	1	2	3	4	5
12.	When I sense pain I feel dizzy or faint.	0	1	2	3	4	5
13.	Pain sensations are terrifying.	0	1	2	3	4	5
14.	When I hurt I think about the pain constantly.	0	1	2	3	4	5
15.	Pain makes me nauseous (feel sick to my stomach).	0	1	2	3	4	5
16.	When pain comes on strong I think I might become paralyzed or more disabled.	0	1	2	3	4	5
17.	I find it hard to concentrate when I hurt	0	1	2	3	4	5
18.	I find it difficult to calm my body down after periods of pain.	0	1	2	3	4	5
19.	I worry when I am in pain.	0	1	2	3	4	5
20.	I try to avoid activities that cause pain.	0	1	2	3	4	5

Thank you for completing this questionnaire.
It will help us to better understand your pain problem.