Welcome to NHS Highland Pain Management Service

Information from this questionnaire helps us to understand your pain problem better. It is important that you read each question carefully and answer as best you can. There are no right or wrong answers. Please try to answer every question. If in doubt, please select the answer which most closely describes your situation.

Name: _____ Date: _____

DOB: _____ Sex: M / F

Telephone N°: _____ Mobile: _____

E-mail: _____

GP: Dr _____ Health Centre: _____

Please tick if you are affected by any of the below

Significant hearing loss ☐

Significant visual impairment ☐

Significant physical limitations ☐

Memory difficulties ☐

Reading or writing issues ☐

1. What would you like to achieve by coming to the pain clinic?

2. How long have you had your pain?

3. How did it start?

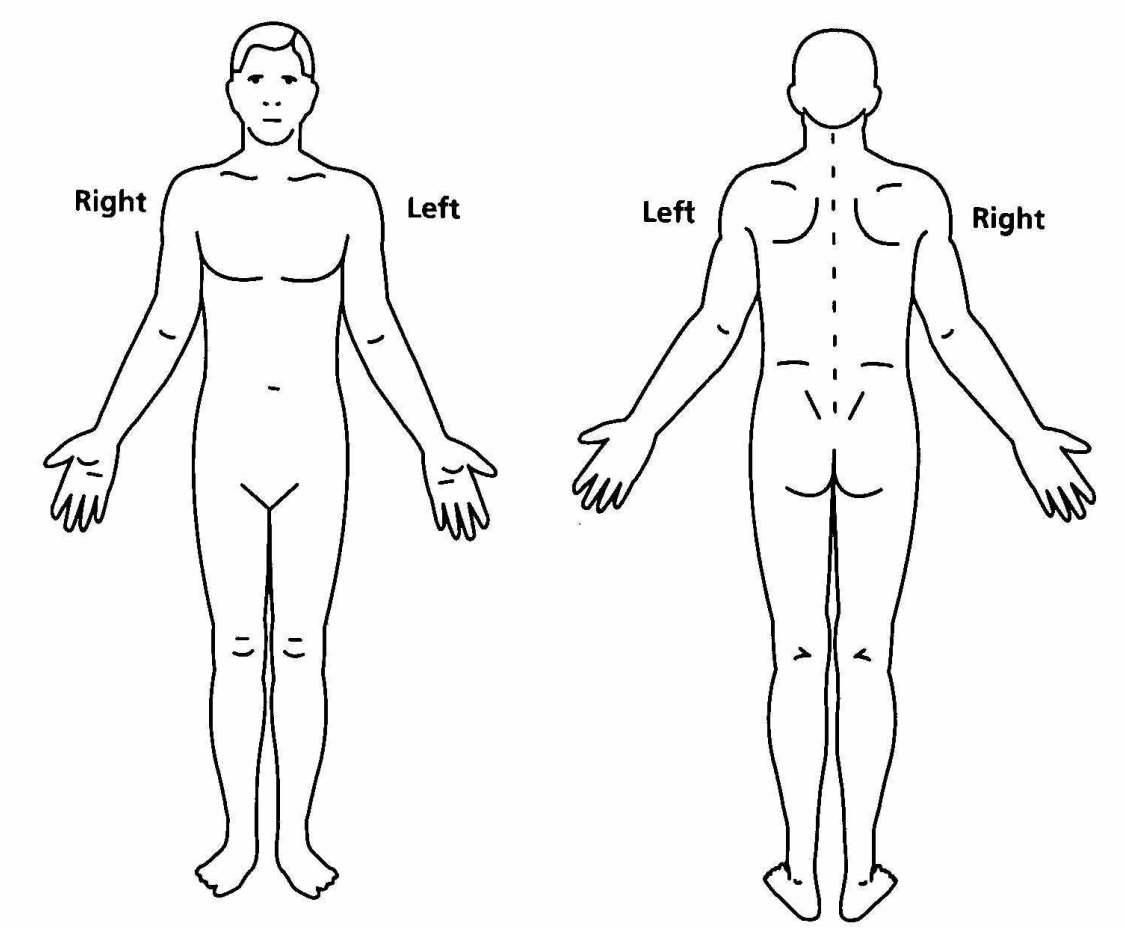
4. Has your pain changed over time?

   Better □
   Same □
   Worse □

5. Describe your pain. (i.e. tingling, burning, throbbing, aching, radiating numbness, stabbing)

6. Draw on the picture where your pain(s) is/are and put a circle around your worst pain(s). Feel free to write on the drawing if this would help using the symbols below to shade the areas.

Numbness	Pins & Needles	Ache	Pain
=========	xxxxxxxxxxxxx	oooo	////



7. What do you think is causing your pain?

8. What investigations have you had for the pain (e.g. x-rays, scans, blood tests, nerve tests)? Please give dates and the hospital if possible

9. What treatments for pain other than medication are you having **now**, or have you tried in the **past**? Tick all of the boxes that apply. Have any of the treatments helped?

Past	Now	Treatment	Helpful?
		Physiotherapy	Y / N
		Acupuncture	Y / N
		TENS	Y / N
		Chiropractic	Y / N
		Osteopathy	Y / N
		Homeopathy	Y / N
		Herbal Remedies	Y / N
		Hypnosis	Y / N
		Psychology	Y / N

10. Please list any operations you have received for your pain problem

11. Do you suffer from any other medical condition not related to the pain?

12. Do you have any allergies? (e.g. Elastoplasts, Antibiotics)

13. Are you currently seeing any other specialist? If yes, please state the hospital and clinic.

    Yes / No

14. Do you need help to look after yourself because of your pain? If, yes, what help do you need?

15. Do you need to use aids or appliances (e.g. wheelchair, crutches, walking stick, back support) because of the pain? If yes please give details.

    Yes / No

16. To what extent have the following areas of your life been affected by your pain?

Job	Not at all				Very much
	1	2	3	4	5
Friends	Not at all				Very much
	1	2	3	4	5
Family Life	Not at all				Very much
	1	2	3	4	5
Social Life	Not at all				Very much
	1	2	3	4	5
Hobbies	Not at all				Very much
	1	2	3	4	5
Exercise	Not at all				Very much
	1	2	3	4	5

17. Do you have a job?

    Yes / No

    If **Yes**, what is it: Full time / Part-time
    To what extent does your pain affect your work?

    If **No**, is this as a result of your pain?

18. Are you receiving or in the process of claiming any state benefits (e.g. unemployment, invalidity, disability, mobility, etc.)? If yes please give details.

19. Have you sought legal advice or made any claim on account of your pain problem?

Yes / No

If yes, please give details.

20. What questions would you like to ask about your pain?

21. What worries you about your pain

22. Do you think you need more medication or stronger medication than you are currently taking? Please circle the answer that most applies to you.

1	2	3	4	5
(agree strongly)	(agree)	(unsure)	(disagree)	(disagree strongly)

23. If in the last week you have had side effects from your pain medications please circle the one number that best shows how severe those side effects have been?

1	2	3	4	5	6	7	8	9	10
No side effects									Severe side effects

24. Do you ever drink alcohol to relieve your pain? NO / YES

Medication Record

Please list all medications that you take at the present time including non-prescription medications.

Medication	Dose	How often	Benefits (tick)				Side effects	Taken for
			Marked	Moderate		Slight	None	

25. What medicines have you tried **<u>in the past</u>** for your pain?

Medication	Dose	How often	Benefits (tick)				Side effects	Taken for
			Marked	Moderate		Slight	None	

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "√" to indicate the answer)	Not at all	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself _ or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite _ being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Add columns TOTAL ____ + ____ + ____

(Healthcare professional: For interpretation of TOTAL please refer to accompanying score card

10. If you checked off any problems, how difficult have these problems made it for you to do you work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____

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Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T_____ = _____ + _____ + _____*)

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute

Your Physical Health

This survey asks for your views about how your pain now affects how you function in everyday life. This information can help you and your pain team know how you feel and how well you are able to do your daily tasks at this time.

Please answer every question by circling one number between 0 and 10 with '0' meaning pain does not interfere and 10 pain interferes severely.

BE SURE TO ANSWER ALL QUESTIONS

1. **Does your pain interfere with your normal work inside and outside the home?**

   Work normally 0 1 2 3 4 5 6 7 8 9 10 Unable to work at All

2. **Does your pain interfere with personal care (Such as washing, dressing, etc)?**

   Take care of myself completely 0 1 2 3 4 5 6 7 8 9 10 Need help with all my personal care

3. **Does your pain interfere with your travelling?**

   Travel anywhere 0 1 2 3 4 5 6 7 8 9 10 Only travel to see doctors I like

4. **Does your pain affect your ability to sit or stand?**

   No problems 0 1 2 3 4 5 6 7 8 9 10 Cannot sit/stand At all

5. **Does your pain affect your ability to lift overhead, grasp objects or reach for things?**

   No problems 0 1 2 3 4 5 6 7 8 9 10 Cannot do at all

6. **Does your pain affect your ability to lift objects off the floor, bend, stoop or squat?**

   No problems 0 1 2 3 4 5 6 7 8 9 10 Cannot do at all

7. **Does your pain affect your ability to walk or run?**

   No problems 0 1 2 3 4 5 6 7 8 9 10 Cannot walk/run at all

8. **Has your income declined since your pain began?**

   No decline 0 1 2 3 4 5 6 7 8 9 10 Lost all income

9. **Do you have to take pain medication every day to control your pain?**

   No medication needed 0 1 2 3 4 5 6 7 8 9 10 On pain medication throughout the day

10. **Does your pain force you to see doctors much more often than before your pain began?**

    Never see doctor 0 1 2 3 4 5 6 7 8 9 10 See doctors weekly

11. **Does your pain interfere with your ability to see the people who are important to you as much as you would like?**

No problem 0 1 2 3 4 5 6 7 8 9 10 Never see them

12. Does your pain interfere with recreational activities and hobbies that are important to you?

No interference 0 1 2 3 4 5 6 7 8 9 10 Total interference

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?

Never need help 0 1 2 3 4 5 6 7 8 9 10 Need help all the time

14. Do you now feel more depressed, tense or anxious than before your pain began?

No depression/tension 0 1 2 3 4 5 6 7 8 9 10 Severe depression/ tension

15. Are there emotional problems caused by your pain that interfere with your family, social or work activities?

No problems 0 1 2 3 4 5 6 7 8 9 10 Severe problems

Here are some things that other patients have told us about their pain. For each statement please circle any number from 1 to 4 to indicate whether you agree or disagree with the statement.

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
1. I'm afraid that I might injure myself if I exercise	1	2	3	4
2. If I were to try to overcome it, my pain would increase	1	2	3	4
3. My body is telling me I have something dangerously wrong	1	2	3	4
4. My pain would probably be relieved if I were to exercise	1	2	3	4
5. People aren't taking my medical condition seriously	1	2	3	4
6. My accident has put my body at risk for the rest of my life	1	2	3	4
7. Pain always means I have injured my body	1	2	3	4
8. Just because something aggravates my pain doesn't mean it is dangerous	1	2	3	4
9. I am afraid I might injure myself accidentally	1	2	3	4
10. Simply being careful that I do not make any unnecessary movements is the safest thing I can do to prevent my pain from worsening	1	2	3	4
11. I wouldn't have this much pain if there weren't something dangerous going on in my body	1	2	3	4
12. Although my condition is painful, I would be better off If I were physically active	1	2	3	4
13. Pain lets me know when to stop exercising so that I do not injure myself	1	2	3	4
14. It's really not safe for a person with a condition like mine to be physically active	1	2	3	4
15. I can't do all the things normal people do because it's too easy for me to get injured	1	2	3	4
16. Even though something is causing me a lot of pain, I don't think it's actually dangerous	1	2	3	4
17. No one should have to exercise when he/she is in pain	1	2	3	4

Pain Rating Scales (5th Vital Sign)

Please mark the scale below to show how **intense** your pain is. Mark one number only.
A zero (0) means no pain, and ten (10) means extreme pain.

How intense is your pain now?

No Pain											Extreme pain
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

How intense was your pain on average last week?

No Pain											Extreme pain
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

Now please use the same method to describe how **distressing** you pain is.

How distressing is your pain now?

Not at all distressing											Extremely Distressing
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

How distressing was your pain on average last week?

Not at all distressing											Extremely Distressing
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

Now please use the same method to describe how much your pain interferes with your normal everyday activities.

Does not interfere											Interferes completely
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

How easy was it to complete this questionnaire?

- ☐ Easy
- ☐ Fairly easy
- ☐ Difficult
- ☐ Very difficult

How detailed did you find this questionnaire?

- ☐ Not detailed enough
- ☐ Just right
- ☐ Too detailed
- ☐ Far too detailed

Thank you for completing this questionnaire.