PAIN HISTORY QUESTIONNAIRE

CHRONIC PAIN OUTREACH PROGRAM

Physician's Unique Identifier: _____

Patient's Unique Identifier: _____

Age : _____ **Gender : M F**

Today's Date: _____
day/month/year

To help us understand your current situation, please complete the following questions as fully as possible. You may skip any question you are not comfortable answering.

1. Please list your pain problems.

_____

_____

2. When did your pain problem(s) start? _____ (*Month/Year)*

3. How did your pain problem(s) begin?

● Pain just began	[ ]	● Motor vehicle accident	[ ]	● After surgery	[ ]
● After an illness	[ ]	● After cancer treatment	[ ]		
● Accident at work	[ ]	● Accident at home	[ ]	● Other accident	[ ]
● Other *(specify)*	[ ]	_____			

Please give us further details _____
_____
_____
_____

4. Are you currently involved in any legal matters regarding your pain problem?

Yes [ ] No [ ] If "Yes", indicate: Insurance [ ] WSIB [ ] CPP [ ] Other [ ]

5. Have you visited an emergency room for your pain in the past 12 **months**?

Yes [ ] No [ ]

If ***YES*** → Number of times: _____

If ***YES*** → Which hospital(s): _____

6. Have you been hospitalized for your pain in the past 12 **months**?

Yes [ ] No [ ]

If ***YES*** → Number of times: _____

If ***YES*** → Which hospital(s): _____

If ***YES*** → Length of stay: _____

7. How many times have you visited your GP in the past 3 months? _____

8. Have you seen other physicians for your pain problem?

Name: Dr. _____ Address: _____
Name: Dr. _____ Address: _____
Name: Dr. _____ Address: _____

9. Of your current pain problem(s), which area hurts the most? _____

10. Which of the following words best describe your pain (check all that apply):

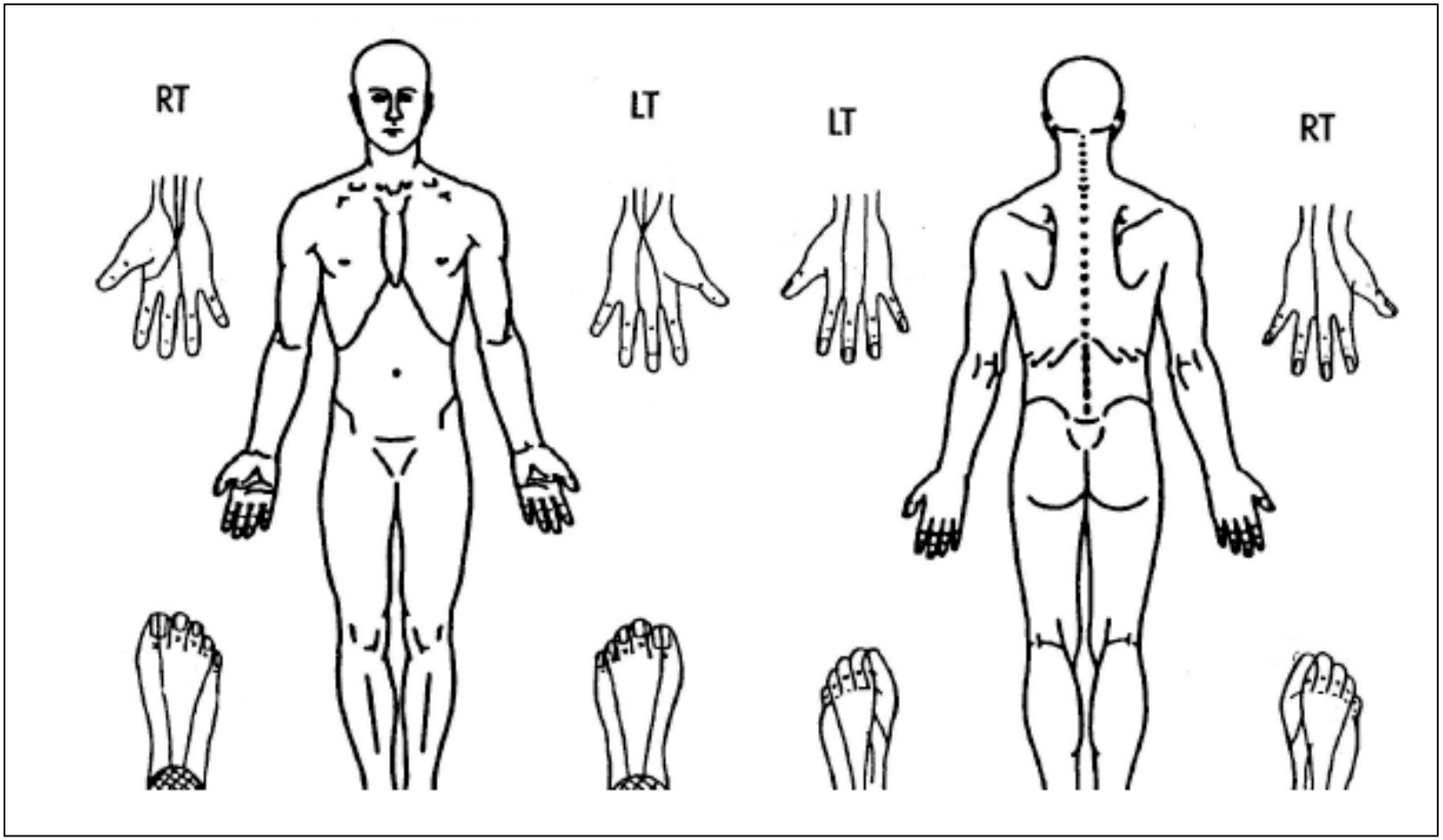
● Tingling	[ ]	● Cramping	[ ]	● Shooting	[ ]	● Heavy	[ ]
● Exhausting	[ ]	● Continuous	[ ]	● Aching	[ ]	● Throbbing	[ ]
● Stabbing	[ ]	● Nagging	[ ]	● Burning	[ ]	● Excruciating	[ ]
● Deep	[ ]	● Sharp	[ ]	● Numb	[ ]	● Unbearable	[ ]

11. Your pain is increased by (CIRCLE those that apply): walking, standing, sitting, bending forward / backward, lifting, coughing / sneezing, lying down, other:

_____
_____

12. Your pain is decreased by (CIRCLE those that apply): heat / ice, low impact activity (walking, swimming...), lying down, sitting, rest, massage, medications, leaning forward on a shopping cart, other:

_____
_____



13. Please shade in the areas where you feel pain. Put an X on the area that hurts the most.

14. Do you have any of the following (circle)?
Urinary incontinence / retention (wetting yourself or not being able to urinate), incontinence of stool (soiling yourself), numbness in the area around your rectum, night sweats (if female are you post-menopausal ? ___), history of cancer (if yes, what cancer _____), unintended weight loss, weakness resulting in falls or dropping things.

15. a) Please rate your **current pain,** by circling a number on the following scale
(where 0 = no pain and 10 = as intense as you can imagine):

0 1 2 3 4 5 6 7 8 9 10

b) Please rate your **worst pain** over the past **week** on the following scale:
(where 0 = no pain and 10 = as intense as you can imagine):

0 1 2 3 4 5 6 7 8 9 10

c) Please rate your **least pain** over the past **week** on the following scale:
(where 0 = no pain and 10 = as intense as you can imagine):

0 1 2 3 4 5 6 7 8 9 10

d) Please rate your **average pain** over the past **week** on the following scale:
(where 0 = no pain and 10 = as intense as you can imagine):

0 1 2 3 4 5 6 7 8 9 10

16. Circle the one number that best describes how, during the **past week**, pain has interfered with your:
a).General Activity
(where 0 = Does not interfere and 10 = Completely interferes):

0 1 2 3 4 5 6 7 8 9 10

b) Mood
(where 0 = Does not interfere and 10 = Completely interferes):

0 1 2 3 4 5 6 7 8 9 10

c) Walking ability
(where 0 = Does not interfere and 10 = Completely interferes):

0 1 2 3 4 5 6 7 8 9 10

d) Normal work
(where 0 = Does not interfere (or N/A) and 10 = Completely interferes):

0 1 2 3 4 5 6 7 8 9 10

e) Relations with other people
(where 0 = Does not interfere and 10 = Completely interferes):

0 1 2 3 4 5 6 7 8 9 10

f) Sleep
(where 0 = Does not interfere and 10 = Completely interferes):

0 1 2 3 4 5 6 7 8 9 10

g) Enjoyment of life
(where 0 = Does not interfere and 10 = Completely interferes):

0 1 2 3 4 5 6 7 8 9 10

17.	Degree of Difficulty				
	No Difficulty	Slight Difficulty	Moderate Difficulty	Extreme Difficulty	Unable to do
a) Dress yourself					
b) Shampoo your hair					
c) Stand up from an armless chair					
d) Get in and out of bed					
e) Walk outdoors on flat ground					
f) Climb up 5 steps					
g) Wash and dry your entire body					
h) Get on and off the toilet. . . .					
i) Bend down and pick up clothing from the floor					
j) Open car doors					
k) Run errands and go shopping					
l) Get in and out of a car . . .					
m) Do chores such as vacuuming					
n) Make meals					
o) Participate in recreational activities					
p) Participate in social activities .					

18. How long can you sit in one position without needing a break or a change in position? _____ min

19. How long can you stand in one position without needing a break or a change in position? _____ min

20. How long can you walk without needing a break? _____ min

21. Please list the pain medications that you have taken over the past **two weeks**:

1- _____ Helpful? Yes [ ] No [ ] If yes ↓Pain by what %____and how long? _____

2- _____ Helpful? Yes [ ] No [ ] If yes ↓Pain by what %____and how long? _____

3- _____ Helpful?Yes [ ] No [ ] If yes ↓Pain by what %____and how long? _____

4- _____ Helpful?Yes [ ] No [ ] If yes ↓Pain by what %____and how long? _____

5- _____ Helpful?Yes [ ] No [ ] If yes ↓Pain by what %____and how long? _____

6- _____ Helpful?Yes [ ] No [ ] If yes ↓Pain by what %____and how long? _____

22. Have you ever run out of medications? Yes [ ] No [ ]; If "Yes" please explain ….

_____
_____

23. Have you ever experienced withdrawal symptoms? Yes [ ] No [ ] ; If "Yes" please explain

_____
_____

24. Have you ever had side effects from your pain medication? Describe

_____
_____

25. Do you have any allergies to medications? Yes [ ] No [ ] ; If "Yes" please list:

_____
_____

26. Do you have any sensitivities to medications (side effects that required discontinuation)? Yes [ ] No [ ]; If "Yes" please list drug(s) and reaction(s):

_____
_____

27. Please check (√) which of the following treatments you have previously received, or are currently receiving for your pain.

Treatment	Previously used, but not now	Currently receiving	Is/was it effective?	How many days, or hours, of relief do/did you get?
a) Bed Rest				
b) Drug Treatment				
c) Physical Therapy				
● TENS				
● Acupuncture				
● Heat therapy				
● Massage therapy				
● Ultrasound				
● Exercise				
● Pool therapy				
● Other (please specify)				
d) Chiropractic				
e) Biofeedback/Relaxation				
f) Injections				
g) Surgery				

28. Have you seen a pain specialist before?
Yes [ ] No [ ]

a) Who was it? _____

b) When did you see him/her last? _____

c) How long was the wait time for the initial appointment? _____

29. Over the ***last 2 weeks***, how often have you been bothered by any of the following problems? Please check (√) only **ONE** box per line.

Item	Not at All (0)	Several Days (1)	More than half the days (2)	Nearly every Day (3)
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling asleep, staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
Trouble concentrating on things such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed OR being so fidgety or restless that you have been moving around a lot more than usual				
Thinking that you would be better off dead or that you want to hurt yourself in some way				
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it's hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

If you checked off any problems in the above question, how difficult, overall, have these problems made it for you to:

a) do your work?
Not difficult at all [ ] Somewhat difficult [ ] Very Difficulty [ ] Extremely difficult [ ]

b) take care of things at home?
Not difficult at all [ ] Somewhat difficult [ ] Very Difficulty [ ] Extremely difficult [ ]

c) get along with other people?
Not difficult at all [ ] Somewhat difficult [ ] Very Difficulty [ ] Extremely difficult [ ]

30. Are you a smoker? ___ ; how many packs per day? ____ For how long? ___ years
Ex smoker for ___ years / ____ months

31. Do you drink any amount of alcohol?
Yes [ ] No [ ] ***If NO, please go to Question 33***

32. In a week, a month, or a year, how many days would you drink any amount of alcohol?
Average number of standard drinks (355 mg beer, 5 oz wine, 1 ½ oz liquor)
Maximum number on one occasion?

a) During the past month, have you thought you should cut down on your drinking of alcohol?

Yes [ ] No [ ]

b) During the past month, has anyone complained about your drinking?

Yes [ ] No [ ]

c) During the past month, have you felt guilty or upset about your drinking?

Yes [ ] No [ ]

d) During the past month has there been a day in which you had five or more drinks of beer, wine, or liquor?

Yes [ ] No [ ]

e) Do you drink to: Relieve the pain?

Yes [ ] No [ ]

f) Do you drink to relax?

Yes [ ] No [ ]

g) Do you drink to socialize?

Yes [ ] No [ ]

h) Do you drink to sleep?

Yes [ ] No [ ]

33. Has anyone in your family had a problem with alcohol abuse?

Yes [ ] No [ ]

34. Has anyone in your family had a problem with street drugs?

Yes [ ] No [ ]

35. Has anyone in your family had a problem with prescription drug abuse?

Yes [ ] No [ ]

36. Have you ever used street drugs?

Yes [ ] No [ ] ***If YES, which one(s):*** _____

37. Have you ever had a problem with prescription drug abuse?

Yes [ ] No [ ] ***If YES, which one(s):*** _____

38. Have you ever been diagnosed with depression, obsessive-compulsive disorder, bipolar disorder, schizophrenia, PTSD, ADD, ADHD, or other personality disorder?

Yes [ ] No [ ] ***If YES, please specify:*** _____

39. Sometimes, adverse childhood experiences can impact a person's physical and mental health. Have you had traumatic experiences in your childhood?

- Verbal/ emotional: Yes [ ] No [ ]
- Physical: Yes [ ] No [ ]
- Sexual: Yes [ ] No [ ]

40. We try to be sensitive to issues of ethnic diversity. In broad terms, how would you categorize your ethnic background:

[ ]Caucasian origin [ ]First Nations origin [ ]Asian origin [ ]African

[ ]Other *(please specify):* _____

41. In what country were you born? _____

42. What is your mother tongue (that is, the first language you spoke as a child)? _____

43. What is your current marital or relationship status?

[ ] Single (never married)

[ ] Single (separated or divorced)

[ ] Married or [ ] Living with partner; How long? _____ *(years)*

[ ] Widowed/Widower. How long? _____ *(Years)*

44. Children:

a) How many children do you have (your own)? _____ (step children)? _____

b) What are your children's ages? _____

c) How many of your children live at home? _____

45. What is your **current** employment status?

- Working - Full-time [ ]
- Working - Part-time [ ]
- Unemployed [ ]
- Retired [ ]
- Homemaker/parenting [ ]
- Sick leave [ ]
- Disability leave - Temporary [ ]
- Disability leave - Permanent [ ]
- Student/retraining - Full-time [ ]
- Student/retraining - Part-time [ ]
- Other *(please specify):* [ ] _____

46. What was your employment status prior to your pain problem?

- Working - Full-time [ ]
- Working - Part-time [ ]
- Unemployed [ ]
- Retired [ ]
- Homemaker/parenting [ ]
- Sick leave [ ]
- Disability leave - Temporary [ ]
- Disability leave - Permanent [ ]
- Student/retraining - Full-time [ ]
- Student/retraining - Part-time [ ]
- Other *(please specify):* [ ] _____

47. What is your current source of financial support? Please check (√) all that apply.

- Salary [ ]
- Self-employment earnings [ ]
- Workers' compensation [ ]
- Work disability insurance - Short term [ ]
- Work disability insurance - Long term [ ]
- Government disability - CPP/Provincial [ ]
- Sick leave income [ ]
- Partner or family support [ ]
- Motor vehicle insurance [ ]
- Savings [ ]
- Lump sum disbursement [ ]
- Retirement pension [ ]
- Social Assistance/Family benefits (FBA) [ ]
- Other *(please specify):* [ ] _____

48. Do you have insurance for medications?

Yes [ ] No [ ] ; If "Yes" specify insurance provider _____

49. Do you have insurance for Allied Health such as PT, Psychology, massage, etc.?

Yes [ ] No [ ] ; If "Yes" specify insurance provider _____

50. Are you worried about your finances and ability to make ends meet? Retire? Etc?

Yes [ ] No [ ]

GOALS

51. List 3 functional goals which you wish to be able to do if your pain is under better control (example: return to work, increase walking / activity level, play with children/grandchildren, use less medications, etc...)?

- _____
_____

- _____
_____

- _____
_____

52. Do you have any specific questions regarding your pain?

- _____
_____

PCS

INSTRUCTIONS:

Using the following 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 that 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

Insomnia Severity Index

For each question below, please circle the number corresponding most accurately to your sleep patterns in the **LAST MONTH.**

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
Difficulty falling asleep	0	1	2	3	4
Difficulty staying asleep	0	1	2	3	4
Problems waking up too early	0	1	2	3	4

How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
0	1	2	3	4

How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little Noticeable	Somewhat Noticeable	Much Noticeable	Very Much Noticeable
0	1	2	3	4

How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all	A Little	Somewhat	Much	Very Much
0	1	2	3	4

To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little Interfering	Somewhat Interfering	Much Interfering	Very Much Interfering
0	1	2	3	4

53. How much improvement would you need, in each of the following areas, in order to feel better? Please circle your responses (only one choice per line item).

Area	No Change	Slight Improvement	Moderate Improvement	Marked Improvement	Return to how I was prior to pain
Pain	1	2	3	4	5
Sleep	1	2	3	4	5
Use of medication	1	2	3	4	5
Activities at home	1	2	3	4	5
Sports and leisure	1	2	3	4	5
Relationships	1	2	3	4	5
Sexual functioning	1	2	3	4	5
Emotional functioning	1	2	3	4	5
Physical functioning	1	2	3	4	5
Ability to work	1	2	3	4	5
Other *(please specify)*	1	2	3	4	5

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE