TRIAL

Queensland Government

Persistent Pain Management Service
Patient Questionnaire

Facility: ....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

This questionnaire requests information which is necessary to assist the Persistent Pain Management Service understand your health needs. It is to be completed before your first appointment.

Section 1: Personal details

1. **Full name:**
   ☐ Mr ☐ Mrs ☐ Miss ☐ Ms
   Family name (surname):
   Given name(s):

2. **Date of birth:**
   / /

3. **Country of birth:** Preferred language:

4. **Residential address:**
   City / town: Postcode:

5. **Contact numbers:**
   Home: Mobile:
   Work: Other:

6. **Medicare number:**

7. **Do you have private health fund cover?**
   ☐ Yes (provide details below) ☐ No

8. **Is there a current compensation case related to your pain problem?**
   ☐ Yes (please select compensation type)
   ◯ Workers Comp
   ◯ Motor Vehicle Accident
   ◯ Public Liability
   Provide insurer name and contact details:
   ☐ No

9. **Family doctor details:**
   Name:
   Address:
   City / town: Postcode:
   Contact number:

10. **Referring doctor details (if different from above):**
    Name:
    Address:
    City / town: Postcode:
    Contact number:

Section 2: Other details

1. **Have you been to a pain service or clinic before?**
   ☐ Yes (provide details below) ☐ No

2. **Are you currently attending a pain service or clinic?**
   ☐ Yes (provide details below) ☐ No

3. **What was your main occupation before your pain / injury?**

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v0.06 - 07/2011 - TRIAL

SW219

PERSISTENT PAIN MANAGEMENT SERVICE - PATIENT QUESTIONNAIRE

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4. What is your current work status:

- ☐ Full time work
- ☐ Part time work (hours)
- ☐ Unemployed due to pain
- ☐ Unemployed due to other reasons
- ☐ Home duties
- ☐ Voluntary work
- ☐ Retired
- ☐ Student
- ☐ Retraining

5 How long has your main pain been present?

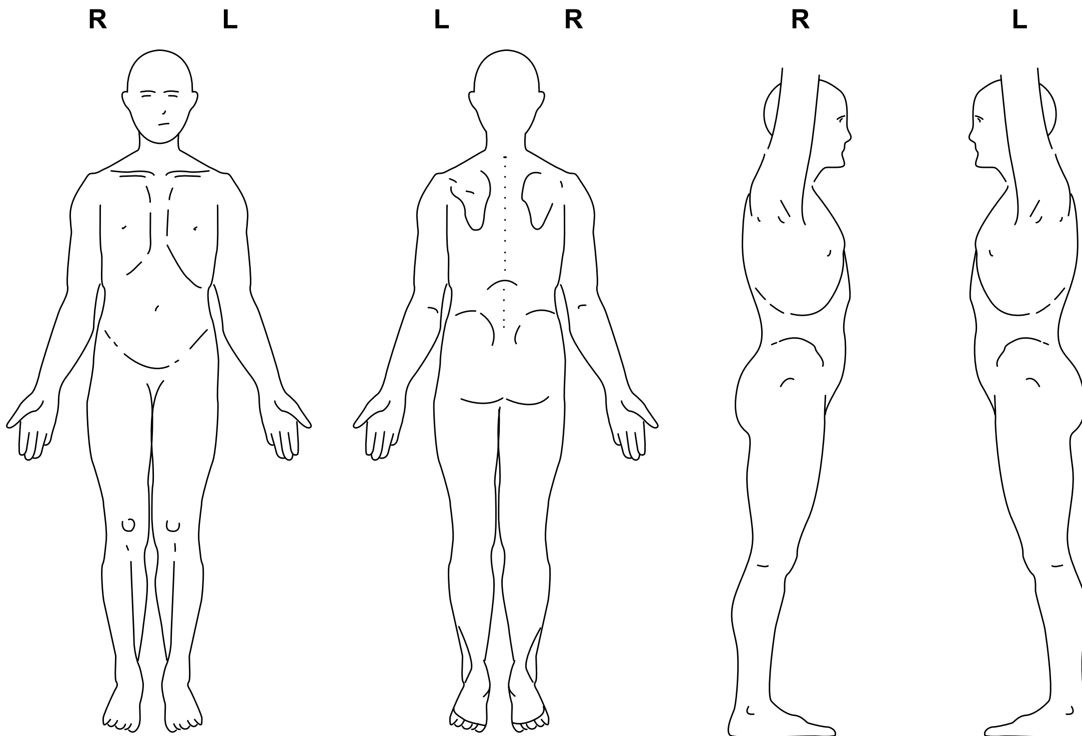
- ☐ 1 month or less
- ☐ 1 month to 6 months
- ☐ 6 months to 12 months
- ☐ 12 months to 3 years
- ☐ 3 to 5 years
- ☐ 5 to 10 years
- ☐ More than 10 years

6. How did your main pain begin?

- ☐ Accident at work
- ☐ After surgery
- ☐ Motor vehicle crash
- ☐ Accident at home
- ☐ Other (provide details below)
- ☐ Related to cancer
- ☐ Related to another illness
- ☐ Pain just began, no clear reason

Section 3: BPI[†]

1. **On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts most.**



2. **Rate your pain by circling the one number that best describes the following...** (circle one of the numbers on the scale next to each item, where ***0 = No pain*** and ***10 = Pain as bad as you can imagine***)

	Scale
a.) Your pain at its worst in the last week?	0 1 2 3 4 5 6 7 8 9 10 No pain … Pain as bad as you can imagine
b.) Your pain at its least in the last week?	0 1 2 3 4 5 6 7 8 9 10 No pain … Pain as bad as you can imagine
c.) Your pain on average?	0 1 2 3 4 5 6 7 8 9 10 No pain … Pain as bad as you can imagine
d.) 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

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3. What treatments and / or medications are you receiving for your pain? (include all herbal and vitamin supplements)

4. In the last week, how much relief have pain treatments or medications provided? (circle the one percentage that best shows how much relief you have received)

0	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No relief										Complete relief

5. During the past week, how much has pain interfered with the following... (circle one of the numbers on the scale next to each item, where ***0 = Does not interfere*** and ***10 = Completely interferes***)

Item	0	1	2	3	4	5	6	7	8	9	10
	Does not interfere										Completely interferes
a.) Your general activity	0	1	2	3	4	5	6	7	8	9	10
b.) Your mood	0	1	2	3	4	5	6	7	8	9	10
c.) Your walking ability	0	1	2	3	4	5	6	7	8	9	10
d.) Your normal work (includes both outside the home and housework)	0	1	2	3	4	5	6	7	8	9	10
e.) Your relations with other people	0	1	2	3	4	5	6	7	8	9	10
f.) Your sleep	0	1	2	3	4	5	6	7	8	9	10
g.) Your enjoyment of life	0	1	2	3	4	5	6	7	8	9	10

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Section 4: K-10*

In the last 4 weeks, how often did you feel... (tick the response that best describes how you felt)	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1.) Tired out for no good reason?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2.) Nervous?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3.) So nervous that nothing could calm you down?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4.) Hopeless?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5.) Restless or fidgety?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6.) So restless that you could not sit still?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7.) Depressed?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8.) That everything was an effort?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9.) So sad that nothing could cheer you up?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
10.) Worthless?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Section 5: PSEQ*

Rate how confident you are that you can do the following things at present despite the pain. (Circle **one** of the numbers on the scale under each item, where ***0 = Not at all confident*** and ***6 = Completely confident***. Remember, this questionnaire is **not** asking whether or not you have been doing these things, but rather how confident you are that you can do them at present, **despite the pain**.)

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

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Section 6: Healthcare utilisation

1. How many times in the past 3 months have you seen a general practitioner in regard to pain?	.... *times*
2. How many times in the past 3 months have you seen medical specialists (e.g. orthopaedic surgeon or neurologist) in regard to pain?	.... *times*
3. How many times in the past 3 months have you seen health professionals other than doctors (e.g. physiotherapist, chiropractor or psychologist) in regard to pain?	.... *times*
4. How many times in the past 3 months have you visited a hospital emergency department in regard to pain?	.... *times*
5. How many days in total over the past 3 months have you been in hospital as an inpatient because of pain?	.... *days*

Section 7: Management

1. Tick any of the following treatments that you have tried, and whether or not they were helpful	Never tried	Helpful	No help	Pain worse	Ongoing
a.) Surgery	☐	☐	☐	☐	☐
b.) Nerve blocks	☐	☐	☐	☐	☐
c.) TENS	☐	☐	☐	☐	☐
d.) Bed rest in hospital	☐	☐	☐	☐	☐
e.) Bed rest with traction	☐	☐	☐	☐	☐
f.) Psychology	☐	☐	☐	☐	☐
g.) Hypnosis	☐	☐	☐	☐	☐
h.) Relaxation	☐	☐	☐	☐	☐
i.) Acupuncture	☐	☐	☐	☐	☐
j.) Chiropractic	☐	☐	☐	☐	☐
k.) Osteopathic	☐	☐	☐	☐	☐
l.) Physiotherapy	☐	☐	☐	☐	☐
m.) Hydrotherapy	☐	☐	☐	☐	☐
n.) Other (please specify: ....)	☐	☐	☐	☐	☐

2. List all the medications you are taking for pain and tick their benefits. Record any side effects.

Medication name	Dose	How often	Benefits				Side effects
			Marked	Moderate	Slight	None	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	
			☐	☐	☐	☐	

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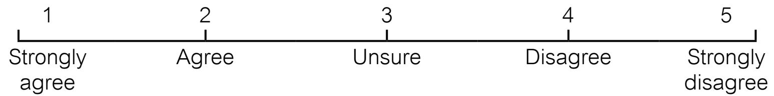
3. **Do you think you need more medication, or stronger medication, than you are currently taking?**



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

4. **List all other medications you are taking not for pain:** (include all herbal and vitamin supplements)

Section 8: Additional details

Question				
1. **What is your smoking status?**	☐ Smoker	☐ Non-smoker	☐ Ex-smoker	
2. **If you currently smoke, how many cigarettes do you smoke in a normal day?**	☐ Less than 5	☐ 5–14	☐ 15 or more	
3. **How many days of the week do you drink alcohol?**	☐ 0	☐ 1–2	☐ 2–3	☐ 4 or more
4. **If you currently drink alcohol, how many standard drinks you usually have on these days?**	☐ 1–2 ☐ 3–4	☐ 5–6 ☐ 7–8	☐ 8–15 ☐ 16 or more	
5. **Do you ever drink alcohol to relieve your pain?**	☐ Yes	☐ No		
6. **How many cups or glasses of caffeinated drinks (i.e. tea / coffee / caffeinated or energy drinks) do you have per day?**	☐ 0 ☐ 1–3	☐ 4–5 ☐ 6–7	☐ 8 or more	
7. **How much do you weigh?**	kg			
8. **How tall are you?**	cm			

Thank you for completing the Patient Questionnaire. Results of this information will be discussed with you and your General Practitioner in the development of your Pain Management Plan.

Office use only

Triage date: / /

URN:

Baseline measures: Pain Severity (BPI): / 10

(To score: In question 2, add A through to D, then divide by 4. Maximum score of 10)

Pain Interference (BPI): / 10

(To score: In question 5, add A through to G, then divide by 7. Maximum score of 10)

K10 Score: / 50

(To score: Add questions 1 through to 10. Maximum score of 50)

PSEQ: / 60

(To score: Add questions 1 through to 10. Maximum score of 60)

Healthcare utilisation: / / / /

Total:

Total daily oral morphine equivalent: mg

(excluding Methadone)

(To score: use Oral Morphine Equivalent Daily Dose (OMEDD) conversion tool, Royal Brisbane and Women's Hospital Multi-disciplinary Pain Centre, v1/06/2011, Fleming, J; 2011. N.B. Not to be used as a clinical tool.)

Methadone daily dosage: mg ☐ N/A

Urgency:
☐ Category 1 (< 30 days)
☐ Category 2 (< 90 days)
☐ Category 3 (< 365 days)

Date of initial service: / /

Signature:

References: † Brief Pain Inventory Short Form, Copyright Cleeland, CS 1994 | ♦ Kessler Psychological Distress Scale, Kessler, RC 1992 |
* Pain Self Efficacy Questionnaire, Nicholas, MK 1989 | With thanks to the Hunter Integrated Pain Service, NSW.

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PAIN MANAGEMENT DIARY

Please use this pain assessment scale to fill out your pain control log

0	1	2	3	4	5	6	7	8	9	10
No pain										Worst pain you can imagine

Date	Time	How severe is the pain? (use above scale)	Where is the pain?	Medicine or non-drug pain control method	How severe is the pain after 1 hour (use above scale)	Activity at time of pain

Please note that this is a sample pain management diary only, different versions are available, please discuss with your care team