Waitemata District Health Board
Te Wai Awhina

SURNAME: _____ NHI _____

FIRST NAMES: _____

DATE OF BIRTH: ___/___/___ SEX _____

Please attach patient label here

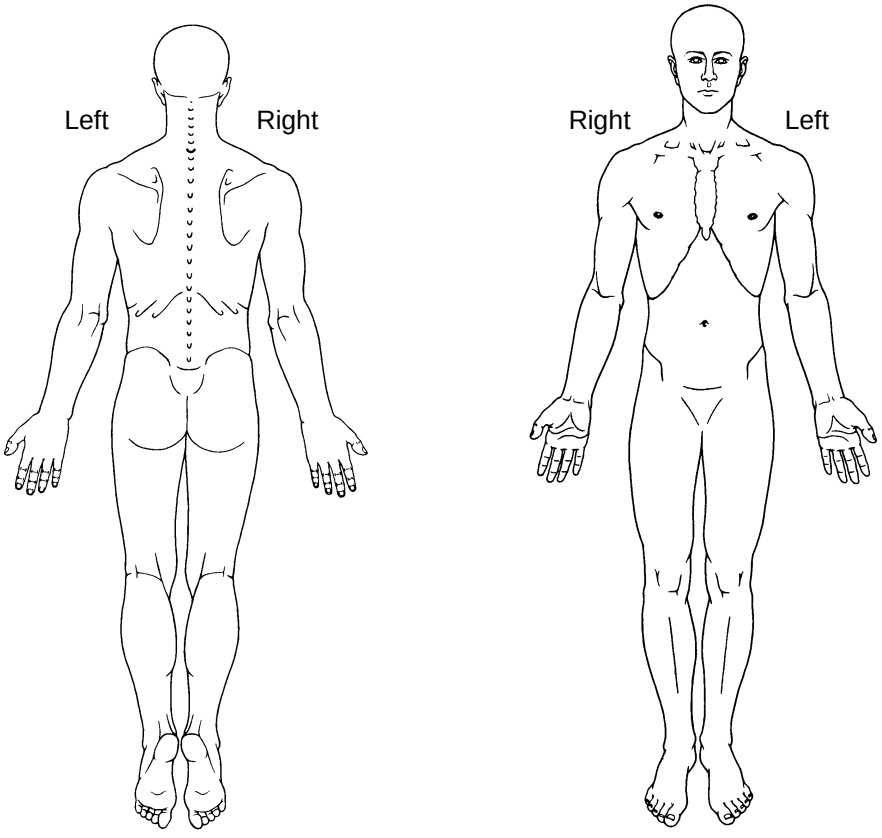
PAIN SERVICE REFFERAL QUESTIONNAIRE

We would appreciate you taking some time to answer this questionnaire. It asks about your pain, and how your pain affects your life and this information is helpful to the Pain Service in prioritising your case and making treatment recommendations. Please return to the Pain Service in the enclosed postage paid envelope.

DESCRIBING YOUR PAIN

Where is Your Pain?

On the diagram below please shade the areas where you experience pain. Put an X on the area that hurts the most.



How long have you had your pain?

_____ (Years) _____ (Months)

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Please circle the words that best describe your pain

Pulsing	Gnawing	Hurtful
Throbbing	Cramping	Heavy
Beating	Crushing	Tender
Pounding	Tugging	Taut
Quivering	Pulling	Rasping
Jumping	Wrenching	Splitting
Flashing	Hot	Cool
Shooting	Burning	Cold
Pricking	Scalding	Freezing
Boring	Searing	Spreading
Drilling	Tingling	Radiating
Stabbing	Itchy	Penetrating
Sharp	Smarting	Piercing
Cutting	Stinging	Tight
Lacerating	Dull	Numb
Pinching	Aching	Drawing
Pressing	Sore	Squeezing
Tiring	Killing	Intense
Exhausting	Wretched	Unbearable
Sickening	Blinding	Nagging
Suffocating	Unfair	Dreadful
Fearful	Shameful	Annoying
Frightful	Terrible	Troublesome
Terrifying	A Weakness	Discomforting
Punishing	Hurtful	Miserable
Gruelling	Torturing	Distressing
Cruel	Agonising	Horrible
Vicious	Nauseating	Excruciating

WORK

1. What was your occupation before your pain/injury: _____

2. What is your current work status?
Please tick (☑) the relevant box(s) below to indicate your work status right now:

- ☐ Full time paid work
- ☐ Part time paid work Hours per week _____
- ☐ Volunteer/Unpaid work Hours per week _____
- ☐ Home duties
- ☐ Retired
- ☐ Studying / Retraining
- ☐ Unemployed due to pain
- ☐ Unemployed for other reason(s) Reason _____

Future work plans (if unemployed):

- ☐ I am actively involved in the process of returning to paid or unpaid work
- ☐ I do intend to return to paid or unpaid work, but not right now
- ☐ I am not intending to return to paid or unpaid work

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HOW PAIN AFFECTS YOU

Circle the one number that describes how, **during the last 24 hours**, pain has interfered with your:

1. General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

2. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

3. Walking Ability

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

4. Normal Work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

5. Relations With Other People

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

6. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

7. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not										Completely Interferes

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Please note how confident you are that you can do the following things at present (despite the pain). To indicate your answer, 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.

0 = Not at all confident, 6 = Completely confident

1. I can enjoy things, despite the pain.

Not at all confident	**0**	**1**	**2**	**3**	**4**	**5**	**6**	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	**0**	**1**	**2**	**3**	**4**	**5**	**6**	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	**0**	**1**	**2**	**3**	**4**	**5**	**6**	Completely confident

4. I can cope with my pain in most situations.

Not at all confident	**0**	**1**	**2**	**3**	**4**	**5**	**6**	Completely confident

5. I can do some form of work, despite the pain. ('Work' includes housework, paid and unpaid work).

Not at all confident	**0**	**1**	**2**	**3**	**4**	**5**	**6**	Completely confident

6. I can still do many of the things I enjoy doing, such as hobbies or leisure activity, despite the pain.

Not at all confident	**0**	**1**	**2**	**3**	**4**	**5**	**6**	Completely confident

7. I can cope with my pain without medication.

Not at all confident	**0**	**1**	**2**	**3**	**4**	**5**	**6**	Completely confident

8. I can still accomplish most of my goals in life, despite the pain.

Not at all confident	**0**	**1**	**2**	**3**	**4**	**5**	**6**	Completely confident

9. I can live a normal lifestyle, despite the pain.

Not at all confident	**0**	**1**	**2**	**3**	**4**	**5**	**6**	Completely confident

10. I can gradually become more active, despite the pain.

Not at all confident	**0**	**1**	**2**	**3**	**4**	**5**	**6**	Completely confident

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HEALTHCARE

How many times in the past 3 months have you seen any of the following in regard to pain?

	Number of Times
General practitioner / family doctor	
Medical specialists (e.g. orthopaedic surgeon, neurologist, rheumatologist)	
Health professionals other than doctors (e.g. nurse, physiotherapist, occupational therapist, psychologist)	
Alternative/Complimentary health professionals (e.g. homeopath, massage therapist, acupuncturist)	
A hospital emergency department	
Admitted in hospital for more than one night because of your pain	

MEDICATIONS

What are your current medications?
Please list all of the medications you are currently taking. Indicate what dose, how often you take them, and for what problem. Please list both over-the-counter and prescription medications (continue on a separate page if necessary). Name and dose is written on the medication container.

	Medication	Dose (mg)	How often	Problem used for
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

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Have you ever taken any of the following medications for your pain?
(Please tick (✓) one box for each medication). If you experienced side effects when taking these medications, please write these down.

	Have Not Tried	No Benefit	Some Benefit	Marked Benefit	Side Effects
Amitriptyline (Amitrip, Amirol)					
Nortriptyline (Norpress, Allegron)					
Imipramine (Tofranil)					
Dothiepin(Dopress, Prothiaden)					
Clonazepam (Paxam, Rivotril)					
Sodium Valproate (Epilim)					
Phenytoin (Dilantin)					
Carbamazepine (Tegretol)					
Gabapentin(Neurontin, Nupentin)					
Clonidine (Catapres)					
Baclofen (Pacifen)					
Mexiletine (Mexitil)					
Morphine (Sevredol, M-eslon)					
Pethidine					
Tramadol(Arrow-tramadol, Tramal)					
Oxycodone (Oxycontin/Oxynorm)					
Codeine(Codalgin, Panadeine)					
Paracetamol (Panadol)					
Diclofenac (Diclax, Voltaren)					
Ibuprofen (Brufen, Nurofen)					
Celecoxib (Celebrex)					
Other (name)					

Do you think you need more pain medication, or stronger medication, than you are currently taking?

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

In the last week, have you had side effects from pain medications or treatments? Please circle the one number that best shows how severe the side effects have been.

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

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effects

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Effects

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FINALLY

What do you feel are your main problems related to your pain?

What do you hope to achieve by attending the pain service at North Shore Hospital?