

Completing this questionnaire will provide an insight into the severity of your pain and will inform your treatment plan.

Name:

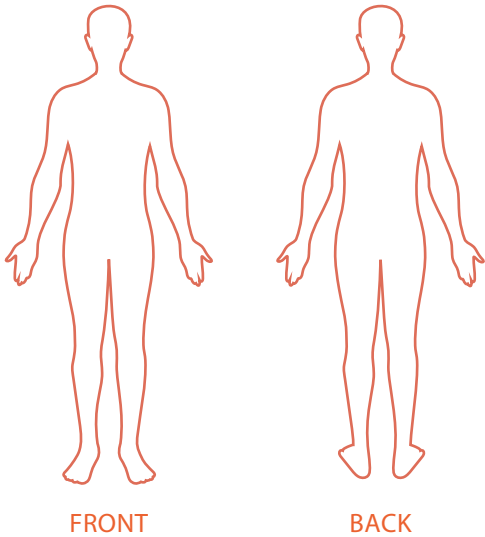
Date: / /

1. Please draw or shade the areas of your pain on the figures.
Put an X on the worst area of pain.

2. How long has the pain been present?
_____ years or _____ months

3. Did your pain start:

- ☐ Suddenly
- ☐ Gradually



4. Was there an incident that caused your pain? *For example lifting injury, fall, car accident.*

5. Is your pain due to a disease? *For example arthritis, diabetes, shingles*

6. What treatments have you had for your pain in the past? *For example medications, surgery, physiotherapy*

Date	Treatment	Helpful?
		yes / no
		yes / no
		yes / no
		yes / no
		yes / no
		yes / no

Please rate your pain by ticking the one number that best describes your pain

7. 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

8. Your pain at its lowest in the last week.

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

No pain

Pain as bad as you can imagine

9. Your pain on average.

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

No pain

Pain as bad as you can imagine

10. 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

11. Is this pain

- ☐ Constant
- ☐ Intermittent (not present all the time)

12. Is the pain:

- ☐ Dull
- ☐ Aching
- ☐ Stabbing
- ☐ Shooting
- ☐ Burning
- ☐ Like an electric shock



13. Is the pain worse at night or when you lie down?

☐ Yes

☐ No

14. What makes your pain feel better? *For example lying down, heat, rest, massage, tablets*

.....

15. What makes your pain worse? *For example standing, sitting, bending, walking*

.....

16. Do you get any of these symptoms in the same area as your pain?

☐ Pins and needles

☐ Numbness

☐ Weakness

17. Since the pain started have you had a problem controlling your bowels or bladder?

☐ Yes

☐ No

18. What medications are you currently using for your pain (including herbal supplements etc)?

Drug/herb/supplement/vitamin/cream	Dose	How often	Helpful?
			yes / no
			yes / no
			yes / no
			yes / no
			yes / no
			yes / no



19. What other treatments are you currently receiving for your pain?

Treatment	Helpful?
	yes / no
	yes / no
	yes / no
	yes / no
	yes / no
	yes / no
	yes / no

20. Are you worried that doing something will make your disease or injury worse?

☐ Yes

☐ No

21. Do you avoid doing things in case they make your disease or injury worse?

☐ Yes

☐ No

22. Do you think that the pain is signalling that something is seriously wrong with you?

☐ Yes

☐ No

23. Do you think your pain may be due to something that has been missed?

☐ Yes

☐ No

24. How much would your pain have to be reduced for you to be able to live with it?

----- %

Tick the one number that describes how, during the past week, pain has interfered with your:

25. General activity

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Does not interfere

Completely interferes

26. Mood

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Does not interfere

Completely interferes

27. Walking ability

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Does not interfere

Completely interferes

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

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Does not interfere

Completely interferes

29. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Does not interfere

Completely interferes

30. Sleep

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Does not interfere

Completely interferes

Tick the one number that describes how, during the past week, pain has interfered with your:

31. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Does not interfere Completely interferes

Use of healthcare

32. How many times in the past 3 months have you seen a general practitioner in regard to pain?

0	1	2	3	4	5	6	7	8	9	10+
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

33. How many times in the past 3 months have you seen medical specialists *(For example orthopaedic surgeon or neurologist)* in regard to pain?

0	1	2	3	4	5	6	7	8	9	10+
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

34. How many times in the past 3 months have you seen health professionals other than doctors *(For example physiotherapist, chiropractor or psychologist)* in regard to pain?

0	1	2	3	4	5	6	7	8	9	10+
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

35. How many times in the past 3 months have you visited a hospital emergency department in regard to pain?

0	1	2	3	4	5	6	7	8	9	10+
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐