BERKSHIRE
PAIN CLINIC

NEW PATIENT QUESTIONNAIRE

This is a confidential questionnaire that will be used only to help understand the type of pain which you are suffering, and the way in which is affects your lifestyle. It enables you to give detailed information and allows us more time for discussion and explanation at your appointment. It may appear daunting at first but please take the time to complete it. Please do not feel that you have to do this all at once: do a little at a time.

Please try and answer all the questions and bring the completed form with you when you come to the appointment.

Date: _____/_____/_____

Name:_____

Address:_____

_____PostCode:_____

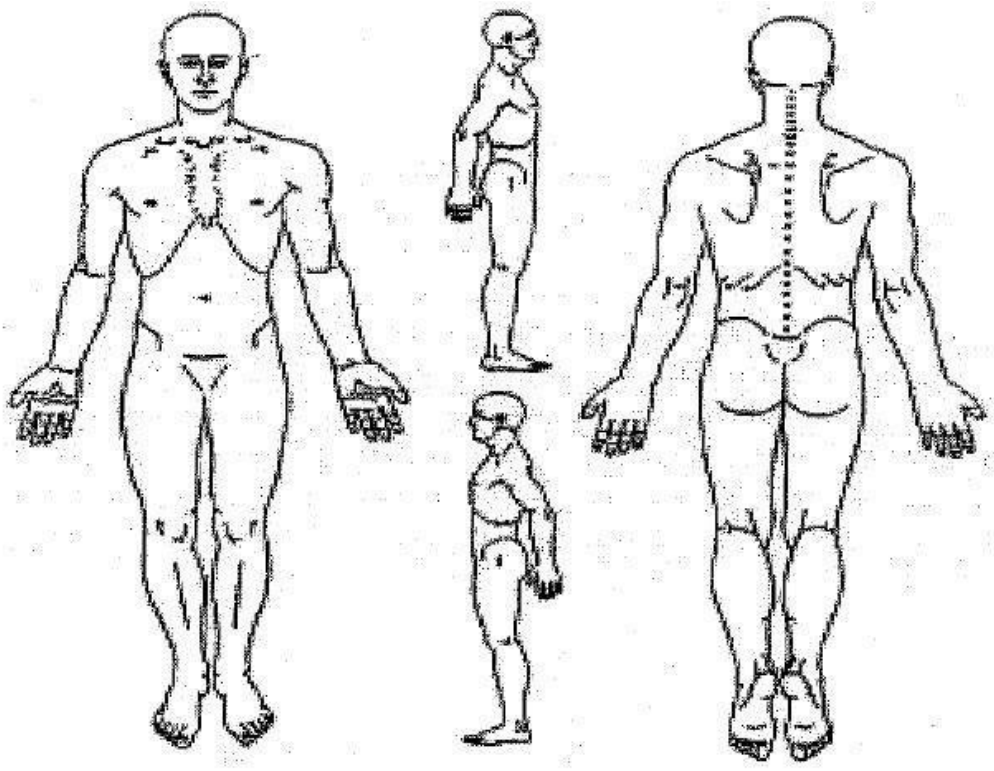
Telephone:Home:_____ Work:_____

Date of Birth: _____/_____/_____

Status: M / S / W / D

1. Where is your pain?

Please make on the drawing below the area where you feel pain. Place an 'X' in the place(s) where you feel the pain the most, and indicate by shading where the pain spreads to other parts of your body. Please also describe how the pain feels to you.



2. **Which word(s) would you use to describe the pattern of your pain?**

Continuous	Rhythmic	Brief
Steady	Periodic	Momentary
Constant	Intermittent	Transient

3. **What types of things relieve your pain?** (e.g. tablets, activities, posture, previous pain treatments, complementary techniques)

_____

_____

4. **What types of things worsen your pain?** (e.g. tablets, activities, posture, previous pain treatments, emotions, stress)

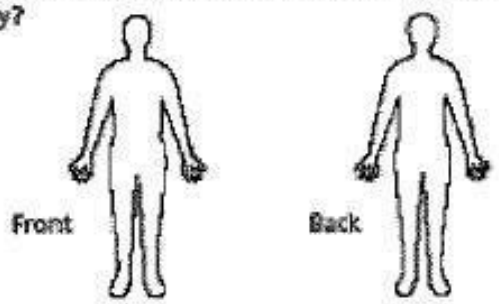
_____

_____

Brief Pain Inventory

Name _____ Date _____ Time _____

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, toothaches). Have you had pain other than these everyday types of pain today?
   1. Yes 2. No
2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its worst in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No pain *Pain as bad as you can imagine*

4. Please rate your pain by circling the one number that best describes your pain at its least in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No pain *Pain as bad as you can imagine*

5. Please rate your pain by circling the one number that best describes your pain on average.

0 1 2 3 4 5 6 7 8 9 10
No pain *Pain as bad as you can imagine*

6. Please rate your pain by circling the one number that tells 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*

7. What treatment or medication are you receiving for the pain?

_____

_____

_____

_____

_____

8. In the past 24 hours, how much relief have pain treatments or medication provided? Please circle the one percentage that most shows how much relief you have received.

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

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10
Does not interfere *Completely interferes*

B. Mood

0 1 2 3 4 5 6 7 8 9 10
Does not interfere *Completely interferes*

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10
Does not interfere *Completely interferes*

D. 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*

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10
Does not interfere *Completely interferes*

F. Sleep

0 1 2 3 4 5 6 7 8 9 10
Does not interfere *Completely interferes*

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
Does not interfere *Completely interferes*

H. Ability to concentrate

0 1 2 3 4 5 6 7 8 9 10
Does not interfere *Completely interferes*

I. Appetite

0 1 2 3 4 5 6 7 8 9 10
Does not interfere *Completely interferes*

5. **Do you have any of the following?** (Circle those that apply)

   a. Numbness? [YES] [NO] if [YES], where? _____
   b. Tingling? [YES] [NO] if [YES], where? _____
   c. Weakness? [YES] [NO] if [YES], where? _____
   d. Incontinence? [YES] [NO]
      If [YES], does it affect [Urine] [Faeces] [Control]

6. **How comfortable are you performing everyday activities?**
   Please tick the appropriate box for how much pain you experienced in the **last 24 hours** whilst performing each of the following everyday activities.

Activity	**No Pain**	**Mild Pain**	**Moderate Pain**	**Severe Pain**
Turning over in bed				
Standing up for short periods				
Walking across a room				
Putting on shoes, socks, stockings, tights				
Coughing or sneezing				
Sitting in a straight backed (dining) chair				
Stooping over a wash hand basin				
Standing for more than 15 minutes				
Walking for more than ¼ mile				

7. **Below are the possible treatments that you may have had for your pain in the past. Please give details/dates where possible and state if they were effective:**

Treatment	**No Receiving**	**In the past**	**Effective (Yes/No)**
Surgery			
Injections			

Psychology/Counselling			
Physiotherapy			
TENS			
Acupuncture			
Osteopath/Chiropractor			
Heat packs			
Anything else?			

8. Please put the names of all the medications / pills you are taking at the moment, including how much (dose in milligrams), and how many times a day

Medication name	**How much (mg)?**	**How many times per day?**

9. Which of these medications/pills above helps your pain?

_____

_____

10. Have any other medications/pills in the past helped your pain?

_____

_____

11. Are you on any blood thinning tablets?

_____

_____

12. Do you have any other medical problems/conditions?

_____

_____

13. What do you think is the cause of your pain?

_____

_____

14. Are you working at the present? [YES] [NO]

a. If [YES], what is your job?

_____

b. If [NO], when did you last have full time employment?

_____

AND was it your present pain that stopped you working? [YES] [NO]

15. Do you have any financial problems due to your pain?

_____

_____

16. Do you receive any benefits/allowances because of your pain?

_____

_____

17. Do you have any legal proceedings pending?

_____

_____

18. What have you given up since you have had your pain?

_____

_____

19. What would you like to be able to do again?

_____

_____

20. What do you think the Pain Clinic can do for you?

_____

_____

21. Please feel free to include any other relevant information below:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Notes on History

Examination Findings

Imaging Results

Differential Diagnosis

Plan