



# PAINXCHANGE

TAILORING PAIN MANAGEMENT ONLINE

## Appendix 1

### General Assessment of Patient's Pain History

# Appendix 1

## General Assessment of Patient's Pain History

Patient Name/ID \_\_\_\_\_

Pain Dimension	Question
<p><b>Location/distribution</b></p> <p>(See "pain location" for body map)</p>	<p><b>Where is your pain?</b></p> <p>_____</p> <p><b>Is the pain localised or does it spread?</b> If so, where does it spread?</p> <p>_____</p> <p>_____</p>
<p><b>Onset</b></p>	<p><b>When did your pain start?</b> Tick one below:</p> <p><input type="checkbox"/> A few days ago</p> <p><input type="checkbox"/> 2-3 weeks ago</p> <p><input type="checkbox"/> 1-3 months ago</p> <p><input type="checkbox"/> 3- 6 months ago</p> <p><input type="checkbox"/> 6-12 months ago</p> <p><input type="checkbox"/> More than 12 months ago</p> <p><input type="checkbox"/> Several years ago</p> <p><b>How did your pain begin?</b> (Tick <u>one</u> response only. If more than one applies, tick the one that applies BEST):</p> <p><input type="checkbox"/> Accident at work</p> <p><input type="checkbox"/> At work, but not involving an accident</p> <p><input type="checkbox"/> Accident at home</p> <p><input type="checkbox"/> Car accident</p> <p><input type="checkbox"/> After surgery</p> <p><input type="checkbox"/> After an illness</p> <p><input type="checkbox"/> Pain just began, no clear reason</p> <p><input type="checkbox"/> Other reasons (please describe) _____</p>
<p><b>Frequency/variation</b></p>	<p><b>Which statement best describes your pain?</b></p> <p><input type="checkbox"/> Always present, always the same intensity</p> <p><input type="checkbox"/> Always present, intensity varies</p> <p><input type="checkbox"/> Usually present, but have short periods without pain</p> <p><input type="checkbox"/> Often present, but have short periods without pain</p> <p><input type="checkbox"/> Often present, but am pain free for much of the day</p> <p><input type="checkbox"/> Occasionally present for brief periods, but not every day</p> <p><input type="checkbox"/> Rarely present – have pain episodes every now and then with days or weeks in between</p>
<p><b>Intensity scale</b></p> <p>(See "pain intensity" for other useful scales to assess pain intensity)</p>	<p><b>On a scale of 0 to 10, where 0 = "no pain"; 5 ="moderate pain" and 10 = "worst possible pain"</b></p> <p>How much does it hurt now? _____</p> <p>How much does it hurt at its worst? _____</p> <p>How much does it hurt at its best? _____</p>

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<b>Characteristic/type</b>	<b>Which of the following best describes your pain?</b> <input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Aching <input type="checkbox"/> Tingling <input type="checkbox"/> Electric shocks
<b>Aggravating and/or contributing factors</b>	<b>List anything that makes your pain worse?</b> (e.g. bad posture, bending) _____ _____ <b>When your pain is particularly bad, what do you do?</b> (rest in bed, take hot showers, use collar/brace) _____ _____ <b>How would you describe your diet?</b> <input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <b>What is your weight?</b> _____ <b>Have you recently experienced weight gain or weight loss?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>How frequently do you engage in light to moderate physical activity?</b> e.g. walking, golf, bowls, swimming <input type="checkbox"/> Every day <input type="checkbox"/> 2-3 times a week <input type="checkbox"/> once a week <input type="checkbox"/> once a fortnight <input type="checkbox"/> once a month <input type="checkbox"/> very occasionally <input type="checkbox"/> never
<b>Relieving factors</b>	<b>What makes your pain better? List activities you do to try to relieve the pain?</b> (e.g. exercise, relaxation, sleep) _____ _____

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<p><b>Impairment/disability</b></p> <p>(See “<u>psychosocial assessment</u>” for more detailed questionnaires)</p>	<p><b>How much does the pain affect your daily activities?</b> Circle one of the following:  <input type="checkbox"/> Not at all    <input type="checkbox"/> Slightly    <input type="checkbox"/> Moderately    <input type="checkbox"/> Quite a bit    <input type="checkbox"/> Extremely</p> <p><b>How much does the pain affect your social life?</b> Circle one of the following:  <input type="checkbox"/> Not at all    <input type="checkbox"/> Slightly    <input type="checkbox"/> Moderately    <input type="checkbox"/> Quite a bit    <input type="checkbox"/> Extremely</p> <p><b>Does the pain cause you to wake at night?</b> <input type="checkbox"/> Yes or <input type="checkbox"/> No</p> <p><b>Have you had changes in mood as a result of the pain?</b> <input type="checkbox"/> Yes or <input type="checkbox"/> No</p>																																																																	
<p><b>Previous pain treatments</b></p>	<p><b>Since your pain began, which of the following people have you seen about it?</b></p> <p><input type="checkbox"/> Acupuncturist  <input type="checkbox"/> Anaesthetist  <input type="checkbox"/> Chiropractor  <input type="checkbox"/> General Practitioner  <input type="checkbox"/> Homeopath  <input type="checkbox"/> Hypnotherapist  <input type="checkbox"/> Neurologist  <input type="checkbox"/> Neurosurgeon  <input type="checkbox"/> Occupational Therapist  <input type="checkbox"/> Orthopaedic Surgeon  <input type="checkbox"/> Physiotherapist  <input type="checkbox"/> Psychologist  <input type="checkbox"/> Psychiatrist  <input type="checkbox"/> Rheumatologist  <input type="checkbox"/> Pain Clinic  <input type="checkbox"/> Others (please specify) _____</p> <p><b>Please tick and rate (using the terms below) any of the following methods that you have used for the treatment of your pain.</b></p> <table border="0"> <tr> <td><input type="checkbox"/> Surgery</td> <td><input type="checkbox"/> Never tried</td> <td><input type="checkbox"/> Tried, helpful</td> <td><input type="checkbox"/> Tried, no help</td> <td><input type="checkbox"/> Tried, pain worse</td> </tr> <tr> <td><input type="checkbox"/> Nerve block</td> <td><input type="checkbox"/> Never tried</td> <td><input type="checkbox"/> Tried, helpful</td> <td><input type="checkbox"/> Tried, no help</td> <td><input type="checkbox"/> Tried, pain worse</td> </tr> <tr> <td><input type="checkbox"/> TENS</td> <td><input type="checkbox"/> Never tried</td> <td><input type="checkbox"/> Tried, helpful</td> <td><input type="checkbox"/> Tried, no help</td> <td><input type="checkbox"/> Tried, pain worse</td> </tr> <tr> <td><input type="checkbox"/> Bed rest in hospital</td> <td><input type="checkbox"/> Never tried</td> <td><input type="checkbox"/> Tried, helpful</td> <td><input type="checkbox"/> Tried, no help</td> <td><input type="checkbox"/> Tried, pain worse</td> </tr> <tr> <td><input type="checkbox"/> Psychology</td> <td><input type="checkbox"/> Never tried</td> <td><input type="checkbox"/> Tried, helpful</td> <td><input type="checkbox"/> Tried, no help</td> <td><input type="checkbox"/> Tried, pain worse</td> </tr> <tr> <td><input type="checkbox"/> Hypnosis</td> <td><input type="checkbox"/> Never tried</td> <td><input type="checkbox"/> Tried, helpful</td> <td><input type="checkbox"/> Tried, no help</td> <td><input type="checkbox"/> Tried, pain worse</td> </tr> <tr> <td><input type="checkbox"/> Relaxation</td> <td><input type="checkbox"/> Never tried</td> <td><input type="checkbox"/> Tried, helpful</td> <td><input type="checkbox"/> Tried, no help</td> <td><input type="checkbox"/> Tried, pain worse</td> </tr> <tr> <td><input type="checkbox"/> Biofeedback</td> <td><input type="checkbox"/> Never tried</td> <td><input type="checkbox"/> Tried, helpful</td> <td><input type="checkbox"/> Tried, no help</td> <td><input type="checkbox"/> Tried, pain worse</td> </tr> <tr> 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worse</td> </tr> <tr> <td><input type="checkbox"/> Pain management</td> <td><input type="checkbox"/> Never tried</td> <td><input type="checkbox"/> Tried, helpful</td> <td><input type="checkbox"/> Tried, no help</td> <td><input type="checkbox"/> Tried, pain worse</td> </tr> </table>	<input type="checkbox"/> Surgery	<input type="checkbox"/> Never tried	<input type="checkbox"/> Tried, helpful	<input type="checkbox"/> Tried, no help	<input type="checkbox"/> Tried, pain worse	<input type="checkbox"/> Nerve block	<input type="checkbox"/> Never tried	<input type="checkbox"/> Tried, helpful	<input type="checkbox"/> Tried, no help	<input type="checkbox"/> Tried, pain worse	<input type="checkbox"/> TENS	<input type="checkbox"/> Never tried	<input type="checkbox"/> Tried, helpful	<input type="checkbox"/> Tried, no help	<input type="checkbox"/> Tried, pain worse	<input type="checkbox"/> Bed rest in hospital	<input type="checkbox"/> Never tried	<input type="checkbox"/> Tried, helpful	<input 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<p><b>Other conditions and treatments</b></p>	<p><b>Do you suffer from any other medical conditions? Please list.</b></p> <hr/> <hr/> <hr/> <p><b>Please list all the medications you are taking at present.</b> Medication/Number per day</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <p><b>List any surgical procedures you have had?</b></p> <table border="0"> <thead> <tr> <th style="text-align: left;">Procedure</th> <th style="text-align: left;">Doctor</th> <th style="text-align: left;">When</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Procedure	Doctor	When																		
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<p><b>Response to treatment</b></p>	<p><b>What medication(s) have been effective in relieving your pain? Please list.</b></p> <hr/> <hr/> <hr/>																					
<p><b>Meaning of the pain</b></p>	<p><b>What do you think is the cause of your pain?</b></p> <hr/> <hr/> <hr/>																					

*These questions are adapted from Cepeda MS et al, "Fast Facts: Chronic Pain" Health Press, 2007 and Scott E et al. Positive Management of persistent pain. SPHERE: a national mental health project. Educational Health Solutions, VIC, 2006.*