

Upper Grand

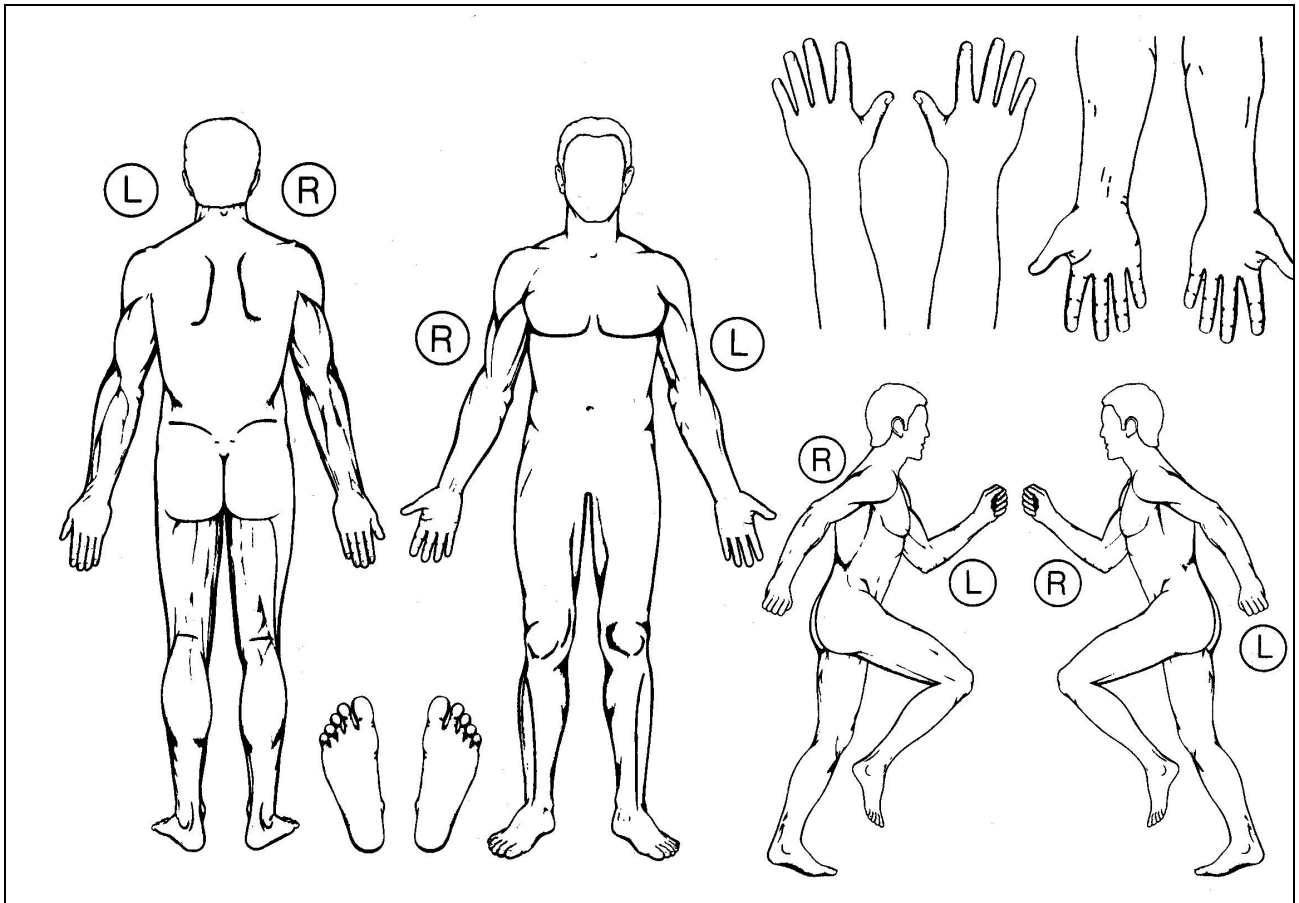
Family Health Team

Patient Questionnaire: Name _____ Date _____

Brief Pain Inventory (Short Form) - Modified

On the diagram below, shade in the areas where you feel pain. Put an "X" on the areas where it hurts the most.

(S=sharp/stabbing, B=burning, N=numbness, P=pins and needles, A=aching, Arrows = shooting pain.



What things make your pain feel worse?

What things make your pain feel better?

Pain Research Group, MD Anderson Cancer Center, 1997

Please rate your pain by circling the one number that best describes your pain at its **WORST** in the past week.

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine
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Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the past week.

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine
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Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**.

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine
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Please rate your pain by circling the one number that tells how much pain you have **RIGHT NOW**.

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain you can imagine
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In the last week, how much relief have your pain treatments or medications provided?
Please circle the one percentage that shows most how much **RELIEF** you have received.

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

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

A. General Activity:

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

B. Mood:

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

C. Walking Ability:

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

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

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

E. Relations with other people:

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

F. Sleep:

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

G. Enjoyment of Life:

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

Hospital Anxiety and Depression Scale (HADS)

Please read each statement below and circle the number which best describes how true the feeling is for you.

	Yes definitely	Yes sometimes	No, not much	No, not at all
1.I wake early and then sleep badly for the rest of the night.	3	2	1	0
2.I get very frightened or have panic feelings for apparently no reason at all.	3	2	1	0
3.I feel miserable and sad.	3	2	1	0
4.I feel anxious when I go out of the house on my own.	3	2	1	0
5.I have lost interest in things.	3	2	1	0
6.I get palpitations, or sensations of 'butterflies' in my stomach or chest.	3	2	1	0
7. I have a good appetite.	0	1	2	3
8. I feel scared or frightened.	3	2	1	0
9. I feel life is not worth living.	3	2	1	0
10. I still enjoy the things I used to.	0	1	2	3
11. I am restless and can't keep still.	3	2	1	0
12. I am more irritable than usual.	3	2	1	0
13. I feel as if I have slowed down.	3	2	1	0

Opioid Risk Tool Patient Form

Please answer the questions below by putting a check mark in any boxes that apply to you. The answers to this questionnaire are confidential and will only be shared with your doctor. If you prefer, you can discuss the answers to any of these questions with the nurse.

1. Is there a family history of drug or alcohol problems in any blood relatives?

- Alcohol
- Illegal Drugs (marijuana, cocaine, etc)
- Prescription Drugs (painkillers, tranquilizers, etc)

2. Have you ever personally had a drug or alcohol problem?

- Alcohol
- Illegal Drugs
- Prescription Drugs

3. Are you between the ages 16 and 45?

4. Do you have a past history of sexual abuse before your teens?

5. Have you ever been diagnosed with any of the mental health problems listed below?

- Attention Deficit Disorder,
Obsessive-Compulsive Disorder,
Bipolar Disorder, Schizophrenia

- Depression

Please tell us about your current pain treatments:

What medications are you taking now?

Prescription Medication: Not taking any prescription medication. ____

Name or type of Drug	Dosage Strength (mgs)	Amount Daily (# pills)	Amount Weekly (# pills)	Helpful? (yes/no)	Any side effects?	Date Started (yy/mm)

Non-prescription Medication (e.g. Tylenol, etc.): Not taking any non-prescription medication. ____

Name or type of Drug	Dosage Strength	Amount Daily	Taken Weekly	Effects	Date Started

Are you taking any complementary/alternative treatments **for your pain**? (eg. glucosamine etc)

Treatment	Effects
_____	_____
_____	_____
_____	_____

Are you scheduled for surgery or any other medical procedures **for your pain** in the future?
 ___ No ___ Yes

If yes, please state what the procedure is and when you expect to have it done.

Please tell us about your previous pain treatments:

Since your pain began, what types of doctors have you consulted? None ____

Type of Doctor	When	What treatment(s) did you receive?	What were the results?
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Since your pain began, what other health professionals have you been treated by?

	When?	What Treatment?	Helpful? (yes/no)	Never Tried
Physiotherapist				
Psychologist				
Chiropractor				
Acupuncturist				
Meditation coach				
Yoga				

Other: (Please describe) _____

Have you ever felt that your condition has not been taken seriously or that you were being treated as if you were faking or exaggerating? ___ No ___ Yes

If yes, please explain: