

PATIENT INFORMATION

Pain Management

Patient Questionnaire

Please complete all questionnaires in this pack

Why These Questionnaires?

- These allow us to better understand how you are affected by your pain
- They also help us to measure changes in your health before and after any treatment you receive in the pain service. This tells us how useful our service has been to you.
- The questionnaire in this pack are widely used in the health service.

How to Fill Them Out

We recognise that people often find some questions difficult to answer. Please answer as best as you can. There are no right or wrong answers to the questions and it is best not to spend too long on any questions.

How Will The Information Be Used?

Information from the questionnaires will be put on to a computer and may be used, in an **anonymous way (without your name identified)**, for audit or research.

Please Sign The Consent Form Below

I agree*/I disagree* to this information being used for audit or research (*please delete as appropriate)

Signed: _____ Date: _____

If you should have any difficulty in completing any of the questionnaires, please ask your health care professional or contact us on 01803 656300.

Please return the questionnaires to your health care professional, the reception or clinic staff.

Thank you.

STUDY ID#

DO NOT WRITE ABOVE THIS LINE

HOSPITAL#

Date: ____/____/____

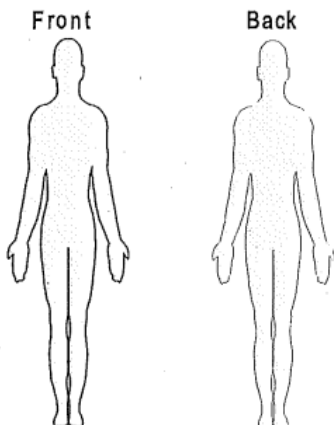
Name: _____
Last First Middle Initial

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains and toothaches). Have you had pain other than these every-day kinds of pain today?

Yes

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 you pain at its worst in the last 24 hours.

0 1 2 3 4 5 6 7 8 10

No Pain

Pain as bad as you can imagine

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

0 1 2 3 4 5 6 7 8 10

No Pain

Pain as bad as you can imagine

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

0 1 2 3 4 5 6 7 8 10

No Pain

Pain as bad as you can imagine

6. Please rate you pain by circling the one number that tells how much pain you have right now.

0 1 2 3 4 5 6 7 8 10

No Pain

Pain as bad as you can imagine

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 10

Does not interfere

Completely
interferes

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