Patient screening questionnaire

Government of South Australia
SA Health

Office use only	
Triage date:	Category:
Pain severity: /10 Pain interference: /10 Pain specific function: /10 K10 score: /10 Health care utilisation: /50 Pain specific function: /50	**Medical assessment:** Anaesthetist / Any **Multidisciplinary assessment:** Anaesthetist / Any Physiotherapy / Psychology / Psychiatry / Any **Nursing / medical assessment**
	GP contact:

Part 1: Screening information

This part of the screening process asks you for information that is helpful to the specialist pain management centre. It will be used to appropriately prioritise your case and make treatment recommendations. **Please contact your local doctor if you need help to complete this form.**

A. Personal details		
Mr/Mrs/Miss/Ms Surname:		
Given names:		
Previous surnames:		
Marital status:	Date of birth: Age:	RAH UR
Address:		
		Post code:
Tel:	Work:	Mobile:
Country of birth:	Language spoken:	
Name and address of family doctor:		
Referring doctor:		

B. Classification

Have you been seen by a pain clinic before? Give details:	
Are you currently visiting a pain clinic? Give details:	
Medicare number:	Do you have private health fund cover? No / Yes
	Name of fund:
Is there a current compensation case related to your pain problem? No / Yes	
If yes, circle type: Workers compensation / Motor vehicle accident / Public liability	
Insurer (name and address)	
Claim no:	Case manager:

C. Work status

What is/was your main occupation before your pain/injury?

What is your current work status? Please tick one.

Full time work		Part time work (hrs)		Unemployed due to pain	
Voluntary work		Home duties		Unemployed due to other reasons	
Retired		Student		Retraining	

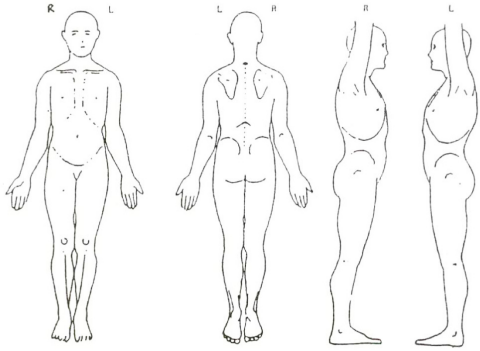
D. Pain details

1. Where is your pain? Please number your sites of pain in order of severity. Mark the most troublesome site '1', the next most troublesome site '2' and so on. Please include all significant sites of pain. If you have total or almost total body pain then you can mark the final option '1' instead of marking each individual site.

__ head, face and/or mouth
__ neck region
__ shoulder(s)
__ arm(s) and/or hand(s)
__ upper back region (thoracic)
__ chest
__ lower back and/or buttocks (lumbosacral)
__ abdominal
__ groin region
__ pelvic
__ anal/genital
__ hip region
__ leg(s) and/or feet
__ total or almost total body pain

D. Pain details, continued...

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts most.



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

0	1	2	3	4	5	6	7	8	9	10
no pain										worst pain

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										worst pain

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										worst pain

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										worst pain

7. Please describe the way your main pain feels to you (eg tingling, burning, throbbing, aching, radiating, numbness, stabbing).

_____

D. Pain details, continued...

8. Which statement describes the typical pattern of your main pain? Please circle the best option.
   - 0 Single episode.
   - 1 Always or almost always present, constant intensity.
   - 2 Always or almost always present, variable intensity.
   - 3 Recurring irregularly (eg like headache).
   - 4 Recurring regularly (eg premenstrual pain).

9. How long has your main pain been present? Please circle the best option.
   Please also give the month and year this pain started if possible _____.
   - 0 1 month or less.
   - 1 1 month to 6 months.
   - 2 6 months to 12 months.
   - 3 12 months to 3 years.
   - 4 3 to 5 years.
   - 5 5 to 10 years.
   - 6 >10 years.

10. How did your main pain begin? Please circle the best option.
    - 0 Accident at work.
    - 1 Accident at home.
    - 2 Motor vehicle crash.
    - 3 After surgery.
    - 4 Related to cancer.
    - 5 Related to another illness_____.
    - 6 Pain just began, no clear reason.
    - 7 Other_____.

E. Pain interference (BPI)

1. Please 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 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

E. Pain interference (B,PI), continued...

2. Many people find that persistent pain interferes with their sexual functioning. Do you find that pain causes interference in this area for you?

Yes ☐ No ☐

If you answered yes then how much does pain interfere with:

a. Your desire for sex

0 1 2 3 4 5 6 7 8 9 10
does not interfere — completely interferes

b. Your enjoyment of sexual activity

0 1 2 3 4 5 6 7 8 9 10
does not interfere — completely interferes

3. Can you identify up to four specific activities that are important to you and that you are unable to do or have difficulty doing as a result of pain (eg brushing hair or hanging washing). Please list these activities and circle the number that best describes your current ability to perform them.

a. _____

0 1 2 3 4 5 6 7 8 9 10
unable to perform — able to perform same as before injury/problem

b. _____

0 1 2 3 4 5 6 7 8 9 10
unable to perform — able to perform same as before injury/problem

c. _____

0 1 2 3 4 5 6 7 8 9 10
unable to perform — able to perform same as before injury/problem

d. _____

0 1 2 3 4 5 6 7 8 9 10
unable to perform — able to perform same as before injury/problem

F. Psychological assessment (K10)					
Please circle the number that best describes how you felt	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. In the last four weeks, how often did you feel tired for no good reason?	1	2	3	4	5
2. In the last four weeks, how often did you feel nervous?	1	2	3	4	5
3. In the last four weeks, how often did you feel so nervous that nothing could calm you down?	1	2	3	4	5
4. In the last four weeks, how often did you feel hopeless?	1	2	3	4	5
5. In the last four weeks, how often did you feel restless or fidgety?	1	2	3	4	5
6. In the last four weeks, how often did you feel so restless that you could not sit still?	1	2	3	4	5
7. In the last four weeks, how often did you feel depressed?	1	2	3	4	5
8. In the last four weeks, how often did you feel that everything was an effort?	1	2	3	4	5
9. In the last four weeks, how often did you feel so sad that nothing could cheer you up?	1	2	3	4	5
10. In the last four weeks, how often did you feel worthless?	1	2	3	4	5
11. In the last four weeks, how many days were you **totally unable** to work, study or manage your day to day activities because of these feelings?	_____ (Number of days)				
12. Aside from those days, in the last four weeks, **how many days** were you able to work or study or manage your day to day activities, but had to **cut down** on what you did because of these feelings?	_____ (Number of days)				
13. In the last four weeks, how many times have you seen a doctor or any other health professional about these feelings?	_____ (Number of days)				
14. In the last four weeks, how often have physical health problems been the main cause of these feelings?	None of the time	A little of the time	Some of the time	Most of the time	All of the time

G. Health care utilisation

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

   0 1 2 3 4 5 6 7 8 9 10 or more

2. How many times in the past three months have you seen medical specialists (eg orthopaedic surgeon, neurologist) in regard to pain?

   0 1 2 3 4 5 6 7 8 9 10 or more

3. How many times in the past three months have you seen health professionals other than doctors (eg physiotherapist, chiropractor, psychologist) in regard to pain?

   0 1 2 3 4 5 6 7 8 9 10 or more

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

   0 1 2 3 4 5 6 7 8 9 10 or more

5. For how many weeks in total over the past three months have you been in hospital as an inpatient because of pain?

   0 1 2 3 4 5 6 7 8 9 10 or more

H. Management

1. Please indicate any of the following treatments that you have tried, and whether or not they were helpful:

	Never tried	Helpful	No help	Pain worse	Ongoing
Surgery					
Nerve blocks					
TENS*					
Bed rest in hospital					
Bed rest with traction					
Psychology					
Hypnosis					
Relaxation					
Acupuncture/acupressure					
Chiropractic					
Osteopathic					
Physiotherapy (hands on)					
Hydrotherapy					

*transcutaneous electrical nerve stimulator

2. Please list any operations you have had relating to your pain problem.

Type of operation	Date	Surgeon

H. Management, continued...

3. Please list all the medications you are taking at present (including those for pain) and indicate whether or not they are helpful.

Medication name	Dose	Benefits *(tick)*				Side effects
		marked	moderate	slight	none	

4. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that best shows how much relief you have received.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

no relief complete relief

5. Please list the medications you have taken in the past for your pain and indicate whether or not they were helpful.

Medication name	Dose	Benefits *(tick)*				Side effects
		marked	moderate	slight	none	

H. Management, continued...

6. Do you think you need more, or stronger, medication than you are currently taking?

1	2	3	4	5
(agree strongly)	(agree)	(unsure)	(disagree)	(disagree strongly)

7. Have you ever smoked regularly? No / Yes

If yes, when did you stop? _____

If you currently smoke, how many cigarettes or pipes do you smoke per day? _____

8. Do you drink alcohol regularly? No / Yes

If yes, on how many days a week would you drink? _____

How many drinks do you usually have on these days? _____

Do you ever drink alcohol to relieve your pain? No / Yes

9. Are there any questions you would like answered if you attend for an assessment at the Royal Adelaide Hospital Pain Management Unit?

10. What are you hoping to achieve if you attend the Pain Management Unit?

Acknowledgement to Hunter Integrated Pain Service for permission to utilise this form.

For More Information

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