Initial Patient Information Questionnaire

This questionnaire booklet is double-sided. Please answer all questions.

When you have finished, please return the question booklet to:

Suite 1
Calvary Clinic
40 Mary Potter Circuit
BRUCE ACT 2617
Email: *info@actpaincentre.com.au*

Telephone: 02 6195 0180
Facsimile: 02 6147 0669

Initial Patient Questionnaire

Section 1 – Patient Information

Title: ☐Mr ☐Mrs ☐Ms ☐Miss	**Family name (surname):**	**Given name(s):**
Gender: ☐ male ☐ female	**Date of birth** ____/____/____	**Today's date:** ____/____/____

Residential / postal address:

City/Suburb State Postcode

Contact details: Home telephone: Work telephone:

Mobile telephone: E-mail:

Country of birth: ☐ Australia ☐ New Zealand ☐ Other (please specify)

Do you require an interpreter? ☐ Yes ☐ No

If you answered yes, please specify the language: ……

Are you hearing impaired? ☐ Yes ☐ No **Are you sight impaired?** ☐ Yes ☐ No

Do you require help with written or spoken communication? ☐ Yes ☐ No

Height (in cm): ..... **Weight (in kg):** ……..

Are you of Aboriginal, Torres Strait Islander or Maori origin? (more than one may be ticked)

☐ No ☐ Yes, Torres strait Islander

☐Yes, Aboriginal ☐ Yes, Maori

Medicare Number: ……..……**Valid to (date): ……**

Ref Number (number in front of your name): ……

DVA card (if applicable) GOLD number……..…WHITE number……..……

Is your condition covered under any of the following: (please tick ✓)

☐ Medicare ☐ Third Party Accident Compensation ☐ Workers' Compensation

☐ Private health cover ☐Veterans' Affairs ☐ Public liability

Do you have private health cover? ☐Yes ☐No

If 'YES' which Fund?……. Membership Number: ……..

Highest level of education ☐ Primary school ☐ Less than year 10 ☐ Year 11 ☐ Year 12 ☐ TAFE/Technical qualification ☐ University Postgraduate

Marital Status ☐ Single ☐ Married/Defacto ☐ Divorced/Separated ☐Widowed

Do You live.. (please tick ✓)

☐ Alone ☐ with a partner/spouse ☐ with children only ☐ with a partner/spouse and child(ren)

☐ with parents ☐ with other relatives ☐ with friends or flatmates

Which of the following best describes your current work status? (more than one may be ticked)

☐ Full time paid employment ☐ Part time paid employment (..... hrs) ☐ Retired ☐ Unemployed due to pain
☐ Unemployed (not pain related) ☐ Home duties ☐ Studying (e.g. school, uni) ☐ Voluntary work
☐ Retraining ☐ On leave from work due to pain ☐ At work – limited hours and/or duties

Does your pain affect the number of hours you are able to work or study? ☐ Yes ☐ No

Does your pain affect the type of work you are able to do? ☐ Yes ☐ No

How did your main pain begin?

☐ Injury at home ☐ Injury at work/school ☐ Injury in another setting ☐ After surgery
☐ Motor vehicle crash ☐ Related to cancer ☐ Related to another illness ☐ No obvious cause
☐ Other .....

How long has the main pain been present? (tick one box only)

☐ Less than 3 months ☐ 3 to 12 months ☐ 12 months to 2 years ☐ 2 to 5 years ☐ More than 5 years

Which statement best describes your pain? (tick one box only)

☐ Always present (always the same intensity)
☐ Always present (level of pain varies)
☐ Often present (pain free periods last less than 6 hours)
☐ Occasionally present (pain occurs once to several times per day, lasting up to an hour)
☐ Rarely present (pain occurs every few days or weeks)

Do you have any of the following medical conditions?

☐ Heart disease ☐ Ulcer or stomach disease ☐ Anaemia or other blood disease ☐ High blood pressure
☐ Kidney disease ☐ Osteoarthritis, degenerative arthritis ☐ Lung disease ☐ Depression / Anxiety
☐ Rheumatoid arthritis ☐ Diabetes ☐ Cancer ☐ Stroke or other neurological condition
☐ Other medical problems (please specify)

Section 2 – Health service use		
1.	How many times in the past 3 months have you seen a general practitioner in regard to your pain?	.....times
2.	How many times in the past 3 months have you seen a medical specialist (e.g. orthopaedic surgeon) in regard to your pain?	.....times
3.	How many times in the past 3 months have you seen health professionals other than doctors (e.g. physiotherapist, chiropractor, psychologist) in regard to your pain?	.....times
4.	How many times in the past 3 months have you visited a hospital emergency department in regard to your pain? Include all visits regardless of whether or not you were admitted to the hospital from the emergency department.	.....times
5.	How many times in the past 3 months have you been admitted to hospital as an inpatient because of your pain?	.....times
6.	How many diagnostic tests (e.g. X-rays, scans) have you had in the last 3 months relating to your pain?	.....times

Name of your General Practitioner:	
Practice Name:	
Address:	
Telephone:	

Name of your Consulting Specialist Doctor (recently seen):	
Practice Name:	
Address:	
Telephone:	
Name of your Solicitor (if relevant):	
Practice Name:	
Address:	
Telephone:	
Name of your Insurance Company (if relevant):	
Claims Manager:	Claim Number:
Address:	
Telephone:	
Name of your Rehabilitation Provider (if relevant):	
Claims Manager:	Claim Number:
Address:	
Telephone:	

Section 3 – Medication use

List all the medications you are taking (include all prescription and over-the-counter medicines)

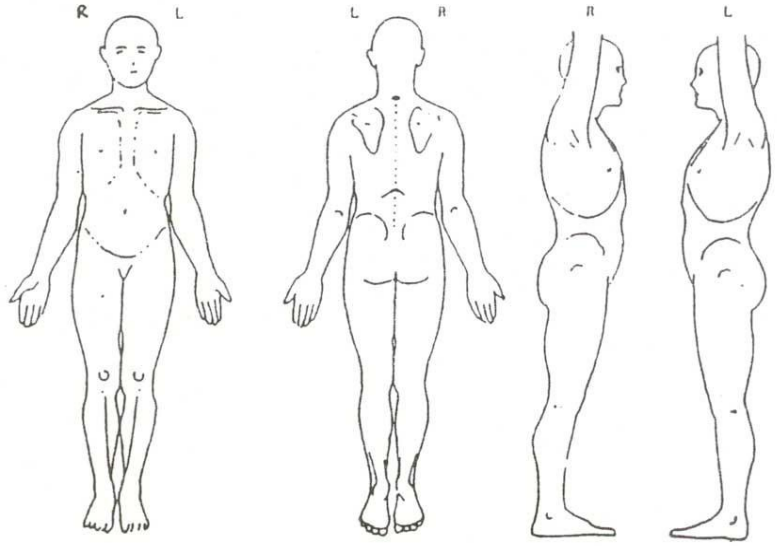
Medicine name (as on the label)	Medicine strength (as on the label)	How many do you take per day?	How many days per week do you take this medication?

Allergies:

Medication name (as on the label)	Reaction

Section 4 – BPI †

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



2. Rate your pain by circling the one number that best describes the following: (circle one of the numbers on the scale next to each item, where 0 = *No pain*, and 10 = *Pain as bad as you can imagine)*

a) Your pain at its worst in the last week?	0 No pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine
b) Your pain at its least in the last week?	0 No pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine
c) Your pain on average?	0 No pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine
d) How much pain do you have right now?	0 No pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine

3. During the past week, how much has pain interfered with the following: (circle one of the numbers on the scale next to each item, where 0 = *Does not interfere*, and 10 = *Completely interferes)*

a) Your general activity?	0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes
b) Your mood?	0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes
c) Your walking ability?	0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes
d) Your normal work (both outside the home and housework)?	0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes
e) Your relations with other people?	0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes
f) Your sleep?	0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes
g) Your enjoyment of life?	0 Does not Interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes

Section 5 – DASS21[#]

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week**. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (e.g. in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Section 6 – PSEQ*

Rate how confident you are that you can do the following things **at present** despite the pain. Circle one of the numbers on the scale under each item where 0 = *Not at all confident* and 6 = *Completely confident*. Remember this questionnaire is not asking whether or not you have been doing these things, but rather how confident you are that you can do them at present, **despite the pain.**

1. I can enjoy things, despite the pain	0 Not al all confident	1	2	3	4	5	6 Completely confident
2. I can do most of the household chores (eg tidying up, washing dishes etc) despite the pain	0 Not al all confident	1	2	3	4	5	6 Completely confident
3. I can socialise with my friends or family members as often as I used to do despite the pain	0 Not al all confident	1	2	3	4	5	6 Completely confident
4. I can cope with my pain in most situations	0 Not al all confident	1	2	3	4	5	6 Completely confident
5. I can do some form of work despite the pain (“work” includes housework, paid and unpaid work)	0 Not al all confident	1	2	3	4	5	6 Completely confident
6. I can still do many of the things I enjoy doing, such as hobbies or leisure activities, despite the pain	0 Not al all confident	1	2	3	4	5	6 Completely confident
7. I can cope with my pain without medication	0 Not al all confident	1	2	3	4	5	6 Completely confident
8. I can still accomplish most of my goals in life despite the pain	0 Not al all confident	1	2	3	4	5	6 Completely confident
9. I can live a normal Lifestyle, despite the pain	0 Not al all confident	1	2	3	4	5	6 Completely confident
10. I can gradually become more active, despite the pain	0 Not al all confident	1	2	3	4	5	6 Completely confident

Section 7 – PCS^

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feeling that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

		Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
1	I worry all the time about whether the pain will end	0	1	2	3	4
2	I feel I can't go on	0	1	2	3	4
3	It's terrible and I think it's never going to get any better	0	1	2	3	4
4	It's awful and I feel it overwhelms me	0	1	2	3	4
5	I feel I can't stand it anymore	0	1	2	3	4
6	I become afraid that the pain will get worse	0	1	2	3	4
7	I keep thinking of other painful events	0	1	2	3	4
8	I anxiously want the pain to go away	0	1	2	3	4
9	I can't seem to keep it out of my mind	0	1	2	3	4
10	I keep thinking about how much it hurts	0	1	2	3	4
11	I keep thinking about how badly I want the pain to stop	0	1	2	3	4
12	There's nothing I can do to reduce the intensity of the pain	0	1	2	3	4
13	I wonder whether something serious may happen	0	1	2	3	4

Section 8 - McGill Questionnaire				
Some of the words below describe your present pain. Underline only those words which best describe it. Use only one word in each group. If more than one word in a group describes your pain, choose the one that describes it best. If no words in a group describe your pain, leave it and go on to the next one.				
1 flickering quivering pulsing throbbing beating pounding	**2** jumping flashing shooting	**3** pricking boring drilling stabbing lancinating	**4** sharp cutting lacerating	**5** pinching pressing gnawing cramping crushing
6 tugging pulling wrenching	**7** hot burning scalding searing	**8** tingling itchy smarting stinging	**9** dull sore hurting aching heavy	**10** tender taut rasping splitting
11 tiring exhausting	**12** sickening suffocating	**13** fearful frightful terrifying	**14** punishing gruelling cruel vicious	**15** wretched blinding
16 annoying troublesome miserable intense	**17** spreading radiating penetrating piercing	**18** tight numb drawing squeezing tearing	**19** cool cold freezing	**20** nagging nauseating agonising dreadful torturing