Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _______ / _______ / _______	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

PAIN MANAGEMENT ADULT REFERRAL QUESTIONNAIRE

REFERRAL QUESTIONNAIRE

Section 1 – Your details

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss	Family name *(surname)*	Given name(s)
Gender ☐ Male ☐ Female	Date of birth *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __	Today's date *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __

Address Number and Street: ....

City/Suburb: .... Postcode: .... State: ....

Phone Home: .... Work: .... Mobile: ....

Email address ....

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 or 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 or Torres Strait Islander origin? *(more than one may be ticked)*

☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Both ☐ Neither ☐ Unknown

Have you ever served in the Australian Defence Force? ☐ Yes ☐ No

Are you a client of the Department of Veterans' Affairs or have you received a benefit or support from the Department of Veterans' Affairs? ☐ Yes ☐ No

Is there a compensation case relating to this episode? ☐ Yes ☐ No

(If yes, record the type of compensation):

☐ Worker's Compensation ☐ Public Liability
☐ Motor Vehicle ☐ Other ....

How did your main pain begin?

☐ Injury at home ☐ Motor vehicle crash ☐ After surgery
☐ Injury at work/school ☐ Cancer ☐ No obvious cause
☐ Injury in another setting ☐ Medical condition other than cancer ☐ Other *(please specify)* ....

How long has your main pain been present? *(Tick one box only)*

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

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PAIN MANAGEMENT ADULT REFERRAL QUESTIONNAIRE

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PAIN MANAGEMENT ADULT REFERRAL QUESTIONNAIRE

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?

☐ A mental health condition, in particular: ☐ PTSD ☐ Anxiety ☐ Depression

Other *(please specify)* ....

☐ Arthritis *(including Rheumatoid/Osteoarthritis)*

☐ Muscle, bone and joint problems other than arthritis *(including Osteoporosis, Fibromyalgia)*

☐ Heart and circulation problems *(including Heart Disease, Pacemaker, Blood Disease)*

In particular specify if you have: ☐ High Blood Pressure ☐ High Cholesterol

☐ Diabetes

☐ Digestive problems *(including IBS, GORD, Stomach Ulcers, Reflux, Bowel Disease)*

☐ Respiratory problems *(including Asthma, Lung Disease, COPD, Sleep Apnoea)*

☐ Neurological problems *(including Stroke, Epilepsy, Multiple Sclerosis, Parkinson's Disease)*

☐ Cancer

☐ Liver, kidney and pancreas problems *(including Pancreatitis, Kidney Disease)*

☐ Thyroid problems *(including Hyperactive or Hypoactive Thyroid, Graves' Disease)*

☐ Any other medical conditions *(please specify)* ....

....

Health care *(other than your visits to the pain clinic)*

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? .... tests

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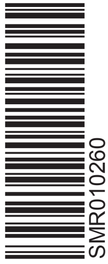

PAIN MANAGEMENT ADULT REFERRAL QUESTIONNAIRE

Section 2 – Your work

Are you currently employed (working for pay)?

☐ Yes - If *yes*, are you:

- ☐ Working full-time
- ☐ Working part-time

Please answer the questions below

☐ No - If *no*, are you:
(tick ***one*** only, then go straight to **Section 3**)

- ☐ Unable to work due to a condition other than pain
- ☐ Unable to work due to pain
- ☐ Not working by choice (student, retired, homemaker)
- ☐ Seeking employment (I consider myself able to work but cannot find a job)

During the past seven days, how many hours did you miss from work because of problems <u>associated with your pain</u>?

(Include hours you missed on sick days, times you went in late, left early, etc. because of your pain. *Do not include time you missed to attend this pain clinic).* ...... hours

During the past seven days, how many hours did you actually work?
*(If '0' skip the next question and go to **Section 3**)* ...... hours

During the past seven days, how much did your pain affect your productivity <u>while you were working</u>?

Think about days you were limited in the amount or kind of work you could do, days you accomplished less than you would like, or days you could not do your work as carefully as usual.

If pain affected your work only a little, choose a low number.
Choose a high number if pain affected your work a great deal.

Consider only how much <u>pain</u> affected productivity <u>while you were working</u>

CIRCLE A NUMBER

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PAIN MANAGEMENT ADULT REFERRAL QUESTIONNAIRE

Section 3 – Medication use

Are you taking any medications?

☐ No *(please go to* ***Section 4****)*

☐ Yes *(Please list all the medications you are taking. Include both 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?

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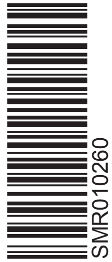

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Section 4 – Pain intensity and interference

On the diagram below, shade in ALL the areas where you feel pain.

FRONT

BACK

RIGHT

LEFT

LEFT

RIGHT

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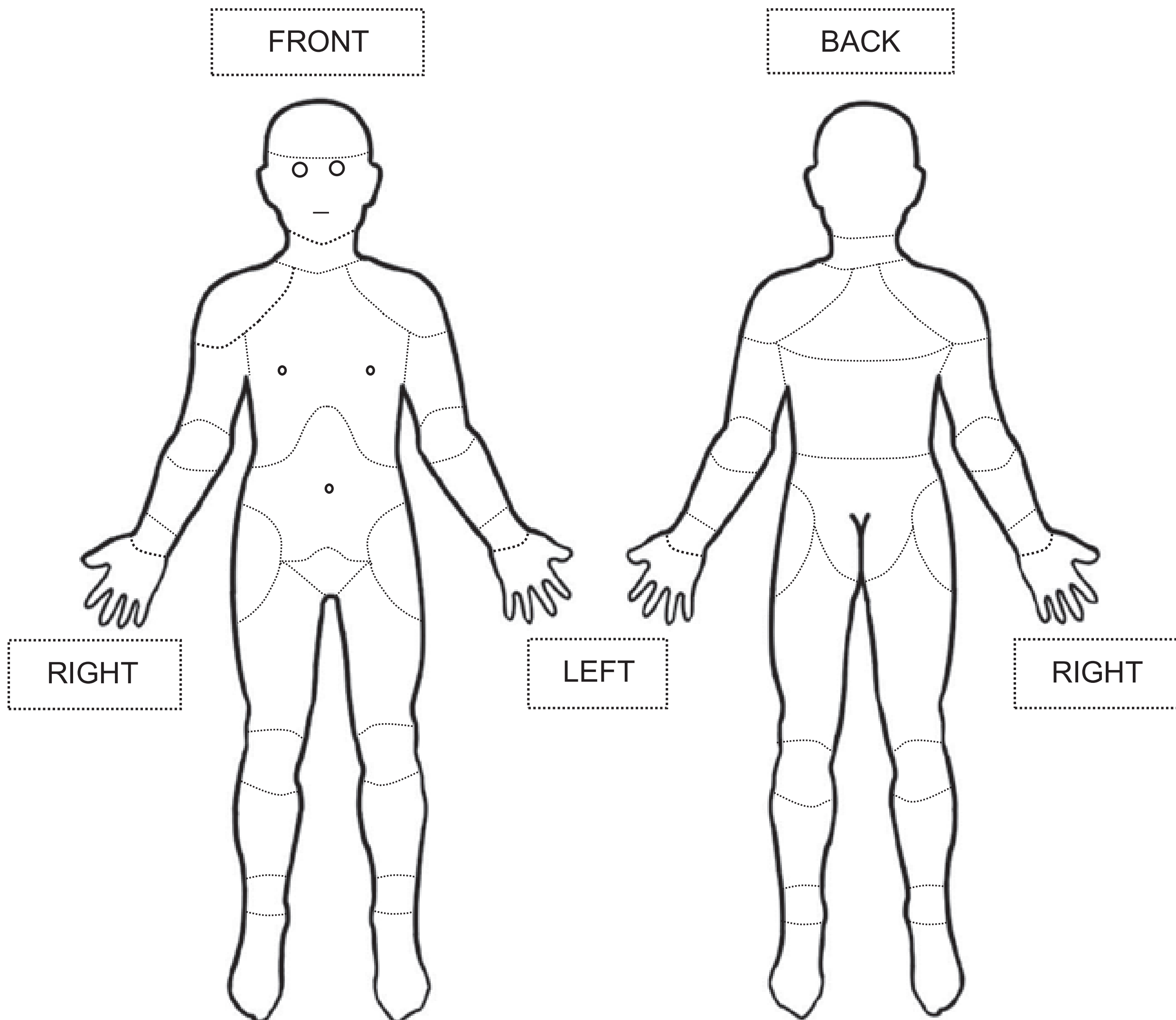
PAIN MANAGEMENT ADULT REFERRAL QUESTIONNAIRE

Section 4 – Pain intensity and interference

On the diagram below, put an X on the ONE area that hurts most.



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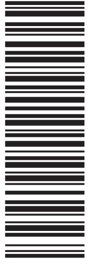

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PAIN MANAGEMENT ADULT REFERRAL QUESTIONNAIRE

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Please rate your pain by circling the one number that best describes the following:

1. 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
2. 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
3. Your pain on *average*?	0 No pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine
4. 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

During the past week, how much has pain interfered with the following:

1. Your general activity?	0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes
2. Your mood?	0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes
3. Your walking ability?	0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes
4. 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
5. Your relations with other people?	0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes
6. Your sleep?	0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes
7. Your enjoyment of life?	0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes

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PAIN MANAGEMENT ADULT REFERRAL QUESTIONNAIRE

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 the time
3 Applied to me very much, or most of the time

	Not at all	Some of the time	A good part of the time	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 overreact 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. a 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

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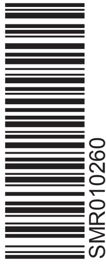

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PAIN MANAGEMENT ADULT REFERRAL QUESTIONNAIRE

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.**

Item	0	1	2	3	4	5	6
1. I can enjoy things, despite the pain	0 Not at all confident	1	2	3	4	5	6 Completely confident
2. I can do most of the household chores (e.g. tidying up, washing dishes, etc.) despite the pain	0 Not at 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 at all confident	1	2	3	4	5	6 Completely confident
4. I can cope with my pain in most situations	0 Not at 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 at 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 activity, despite the pain	0 Not at all confident	1	2	3	4	5	6 Completely confident
7. I can cope with my pain without medication	0 Not at 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 at all confident	1	2	3	4	5	6 Completely confident
9. I can live a normal lifestyle, despite the pain	0 Not at all confident	1	2	3	4	5	6 Completely confident
10. I can gradually become more active, despite the pain	0 Not at all confident	1	2	3	4	5	6 Completely confident

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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 feelings 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

Thank you for completing this questionnaire

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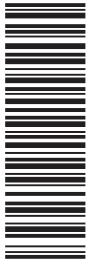

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Medication

Did the patient report medications? ☐ Yes ☐ No

Possible differences in patient-reported medications? ☐ Yes ☐ No

Tick all drug groups being taken:

☐ Opioids ☐ Paracetamol ☐ NSAIDs ☐ Medicinal Cannabinoids

☐ Antidepressants ☐ Anticonvulsants ☐ Benzodiazepines

Daily oral morphine equivalent: …………………… mg

Opioid medication >2 days/week ☐ Yes ☐ No

Opioid replacement/substitution program? ☐ Yes ☐ No

Acknowledgements

We acknowledge use of the following questions and assessment tools:

- Pain Chart: Childhood Arthritis and Rheumatology Research Alliance, www.carragroup.org von Baeyer CL et al, Pain Management, 2011;1(1):61-68
- Modified Brief Pain Inventory questions, reproduced with acknowledgement of the Pain Research Group, the University of Texas MD Anderson Cancer Centre
- Depression, Anxiety and Stress Scale, Lovibond SH & Lovibond PF (1995)
- Pain Self-Efficacy Questionnaire, Nicholas MK (1989)
- Pain Catastrophising Scale, Sullivan MJL (1995)
- Work productivity questions from the Work Productivity and Activity Impairment Questionnaire, Reilly MC, Zbrozek AS & Dukes EM (1993)

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