

Client Information

Date of assessment: ____/____/____

Time of assessment: _____

Name of client: _____

Address: _____

DOB: ____/____/____

Gender: F / M

Diagnosis: _____ Complete / Incomplete

Date of onset of spinal damage: congenital or date: ____/____/____

Cause of Injury:

- | | | | |
|--------------------------------------|---|---|--|
| <input type="checkbox"/> Diving | <input type="checkbox"/> Fall | <input type="checkbox"/> MVA | <input type="checkbox"/> MBA |
| <input type="checkbox"/> Pedestrian | <input type="checkbox"/> Football | <input type="checkbox"/> Other traumatic eg assault | <input type="checkbox"/> Gunshot wound |
| <input type="checkbox"/> Other sport | <input type="checkbox"/> Disease (diagnosis: _____) | | |

Did you have surgery at the time of your initial injury? Yes / No

Any relevant medical information: eg sciatica, IHD, psychiatric disorder etc

SECTION A: DEMOGRAPHIC DATA

Marital Status:

- | | |
|--|---|
| <input type="checkbox"/> Never Married | <input type="checkbox"/> Separated/divorced |
| <input type="checkbox"/> Married | <input type="checkbox"/> Other _____ |

Highest level of education:

- | | | |
|--------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Primary | <input type="checkbox"/> Trade Qualification | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> High School | <input type="checkbox"/> Still at school | _____ |
| <input type="checkbox"/> Tertiary | <input type="checkbox"/> Never attended school | _____ |

Employment status:

- | | | |
|--|---|--|
| <input type="checkbox"/> Employed / self employed (occupation) _____ | <input type="checkbox"/> Home duties | <input type="checkbox"/> Unemployed/unable to work |
| <input type="checkbox"/> Student | <input type="checkbox"/> Voluntary work | <input type="checkbox"/> Retired |

Source of income:

- | | | |
|---|---|---|
| <input type="checkbox"/> Private income | <input type="checkbox"/> Superannuation | <input type="checkbox"/> Workers compensation |
| <input type="checkbox"/> Centrelink payment _____ | <input type="checkbox"/> Veterans Affairs | <input type="checkbox"/> Other _____ |

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ACTIVITY LEVEL

Please indicate any hobbies or leisure activities you were or are currently undertaking. Indicate the frequency of the activity by the key:

Hobbies / Leisure Activity	Frequency	
	Before the Injury	After the Injury

Key
Daily
3-6 times per week
1-2 times per week
fortnightly
monthly
occasionally
never

Have you had any pain during the last 7 days including today?

Yes / No

If your answer is:

Yes → Please Go on

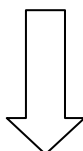
No → You have finished the questionnaire.

If yes, how many different pain problems do you have?

Circle a number in the box below.

- 1 – One pain problem
- 2 – Two pain problems
- 3 – Three pain problems
- 4 – Four pain problems
- 5 – Five or more pain problems

Go on to describe the three (3) worst pain problems in section B



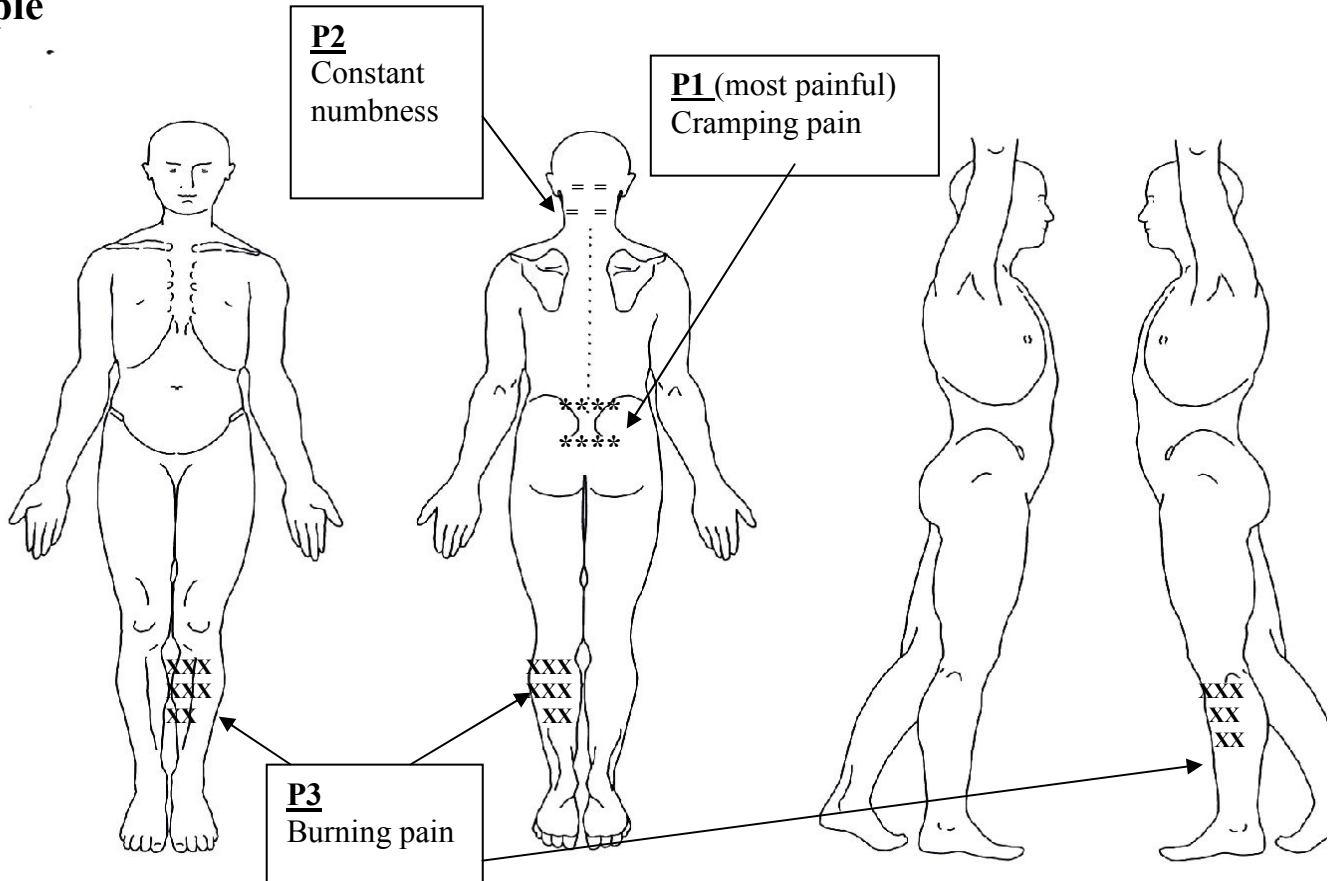
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SECTION B: PAIN LOCATION (S):

- D) On the diagram below is a description of how to fill in the body diagram, showing where you feel your pain
- Shade areas where you feel pain.
 - Mark **P1** as the pain that hurts the most, **P2** as the second and **P3** as the third
 - Rate each of these pain areas according to the legend on the left side of the diagram

Example



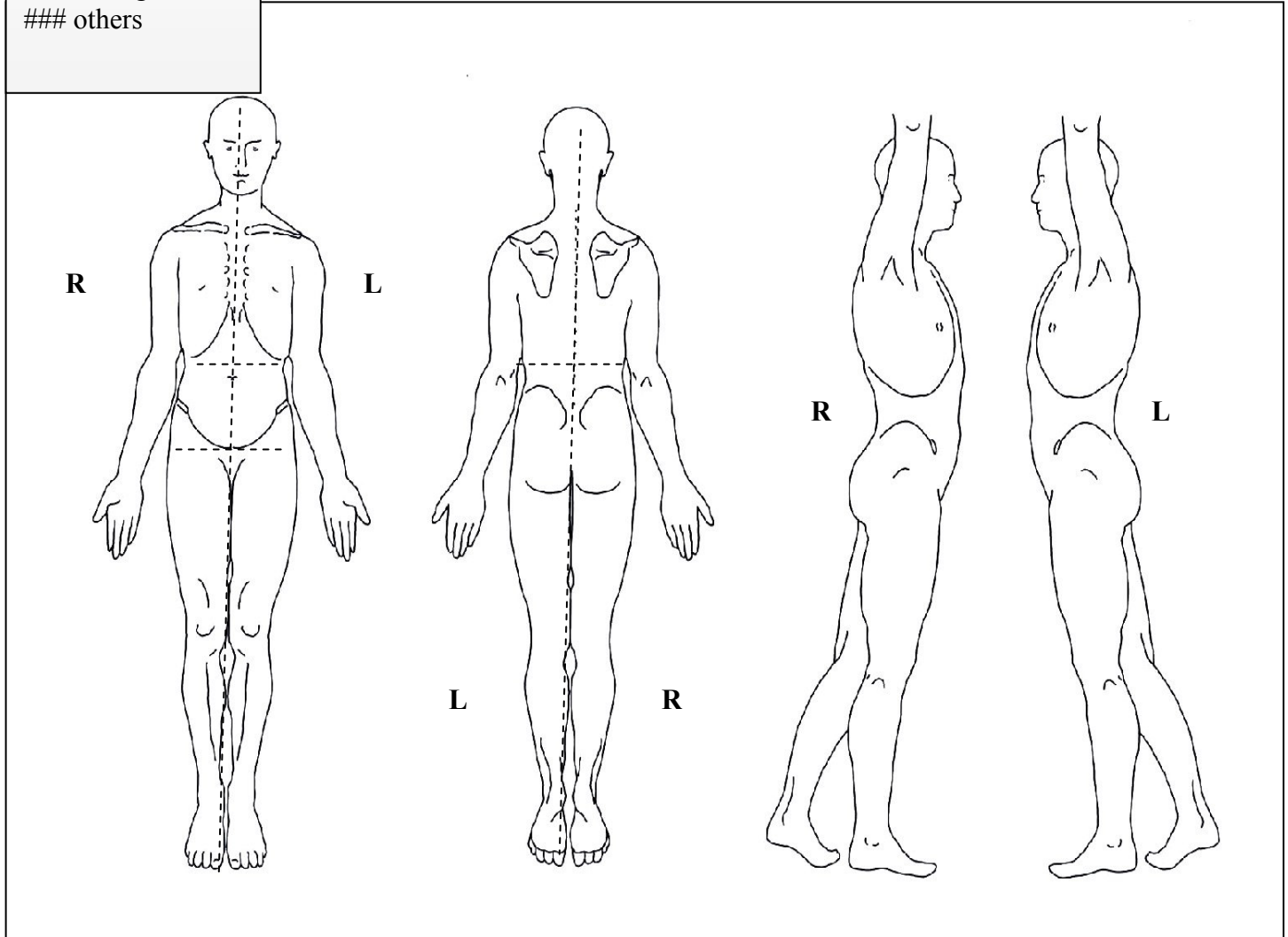
Pain Description
xxx burning
= = numbness
*** cramping
!!! stabbing
ooo aching
others

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Pain Description

xxx burning
== numbness
*** cramping
!!! stabbing
ooo aching
others



-> Please indicate your pain areas as per key and example above.

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TYPE OF PAIN

Please mark the type of pain present. If you have more than 1 pain, use P1, P2 and P3 to indicate the pain you are referring to. P1 refers to the worst pain.

Nociceptive <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Visceral <input type="checkbox"/> Other Neuropathic <input type="checkbox"/> At Level <input type="checkbox"/> Below Level <input type="checkbox"/> At <u>and</u> Below Level <input type="checkbox"/> Other
--

AVERAGE PAIN INTENSITY

Please rate your pain by indicating the number that best describes your pain on average in the last seven (7) days including today.

If you have more than one pain, circle a score for each pain. P1 should be pain the hurts the worst and so on.

no pain 0 1 2 3 4 5 6 7 8 9 10 pain as bad as you can imagine

Example: no pain 0 1 2 3 4 5 6 7 8 9 10 pain as bad as you can imagine
--

WHEN DID THE PAIN START?

Fill in the date that the pain started using the format: YYYY/MM/DD.

If the day of the month is unknown, record 99. If the month of the year is unknown, record 99. The year should be given as an approximation if it is not known.

P1 ____ / ____ / ____
P2 ____ / ____ / ____
P3 ____ / ____ / ____

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NUMBER OF DAYS WITH PAIN IN THE LAST 7DAYS INCLUDING TODAY

Circle one of the values below.

“Today” is the day you answer the question regardless of the time of day. The duration of pain during the day does not matter in answering this question

0 – none
1 – one day
2 – two days
3 – three days
4 – four days
5 – five days
6 – six days
7 – seven days
Unknown

HOW LONG DOES YOUR PAIN USUALLY LAST/

Only fill this in if a specific pain follows a predictable pattern. If no predictable pattern for a pain exists, mark unknown.

One minute or less
More than one minute but less than one hour
At least one hour, but less than 24 hours
At least 24 hours
Constant or continuous
No pain
Unknown

PAIN INTENSITY

When is your pain most intense?

Mark one of these. Definitions of each are as follows: “Morning” is between 6.01am and 12.00am; “Afternoon” is between 12.01pm and 6.00pm; “Evening” is between 6.01pm and 12.00pm; “Night” is between 0.001am and 6.00am. Use P1, P2 and P3 for the 3 different pains.

Morning
Afternoon
Evening
Night
Unpredictable; pain is not consistently more intense at any one time of day

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PAIN INTERFERENCE

How much do you limit your activities in order to keep your pain(s) from getting worse?

0 1 2 3 4 5 6

“0 = “not at all”

“6” = “very much”

How much has your pain changed your ability to take part in recreational and other social activities?

0 1 2 3 4 5 6

“0 = “not at all”

“6” = “very much”

How much has your pain changed the amount of satisfaction or enjoyment you get from family – related activities?

0 1 2 3 4 5 6

“0 = “not at all”

“6” = “very much”

In general, how much as pain interfered with your day-to-day activities in the last week?

0 1 2 3 4 5 6

“0 = “no interference”

“6” = “extreme interference”

In general, how much has pain interfered with your overall mood in the past week?

0 1 2 3 4 5 6

“0 = “no interference”

“6” = “extreme interference”

In general, how much has pain interfered with your ability to get a good night’s sleep?

0 1 2 3 4 5 6

“0 = “no interference”

“6” = “extreme interference”

Are you using or receiving any treatment for your pain problem?

YES / NO

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SECTION C: PREVIOUS TREATMENTS FOR PAIN

I) MEDICATION

Please list drugs that you have used. Where possible also list the last dose you were using, how much relief have pain treatments or medications provided for the worst pain (P1) in % from 0% - 100%, any side effects you experienced and whether you are still using the drug or stopped using it.

Medication	Dosage	Pain Relief	Any side effects	Current drug / stopped using it
<i>Eg Gabapetin</i>		<i>20%</i>	<i>Nil</i>	<i>current</i>

II) HEALTH PROFESSION SERVICES AND INTERVENTIONS

Please indicate the “health profession” services and interventions you have tried in the past.

Indicate whether it has affected your pain using the above key:

PAST INTERVENTIONS	Tried it?	Effect
Physiotherapy	Yes/No	
Chiropractor	Yes/No	
Pain Clinic	Yes/No	
Bowen therapy	Yes/No	
Osteopath	Yes/No	
Alternative medicine	Yes/No	
Others: _____	Yes/No	

↑ increased ↓ decreased N no effect on pain

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PAST INTERVENTIONS	Tried it?	Effect
Hydrotherapy	Yes/No	
Prescribed exercise	Yes/No	
TENS	Yes/No	
Heat	Yes/No	
Acupuncture	Yes/No	
Massage	Yes/No	
Relaxation	Yes/No	
Counseling	Yes/No	
Surgery	Yes/No	
Nerve Blocks	Yes/No	
Others: _____ _____	Yes/No	

III) INVESTIGATIONS

Indicate what, if any, investigations have been done regarding your pain

Investigation	Yes / No	What was reported about the test
a. X-ray	Yes / No	
b. MRI	Yes / No	
c. Myelogram	Yes / No	
d. CT scan	Yes / No	
e. Ultra Sound	Yes / No	
f. Others: _____		