



**Queensland
Government**

**Patient Entry Questionnaire
North Queensland Persistent Pain
Management Service (NQPPMS)**

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

This questionnaire asks for information that will help the Persistent Pain Management Service understand your health needs. It is to be completed before your first appointment.

Patient Declaration

I, will provide complete and accurate information.

- I understand that a pain management education and motivation day is likely to be the first part of my treatment with the Persistent Pain Management Service ('the service').
- I understand that opioids, (including MS Contin, Kapanol, OxyContin, Endone, Oxynorm, Targin, Journista, Durogesic and Norspan) will not be prescribed by the service. Recommendations are made by the service to my General Practitioner (GP) who is my prescribing doctor.
- I understand that urinary drug screening may be required.
- I consent to the sharing of my health information with other practitioners involved with my care, including the Medicines Regulation and Quality.
- I understand that the service does not provide medico-legal reports.
- I will endeavor to attend each appointment arranged for me. If I fail to attend my first appointment, or two consecutive appointments, I will be discharged from the service. This is in line with Queensland Health Outpatients Implementation Standards 2010.

Signed: Date: / /

Pain Management Service Use & Occupation History

1. Have you been to a pain service or clinic before? No Yes (provide details below)

.....
.....

2. Are you currently attending a pain service or clinic? No Yes (provide details below)

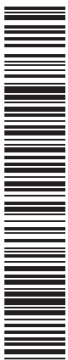
.....
.....

3. What was your main occupation before your pain / injury?

.....
.....

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v3 - Last reviewed 12/17



00200:ADM-060-0863

PATIENT ENTRY QUESTIONNAIRE



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Section 1 - Your Details

Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss	Family name (surname):	Given name(s):
-------------------------------------------------------------------------------------------------------------------------------------	-------------------------------	-----------------------

Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth: / /	Today's date: / /
------------------------------------------------------------------------------	---------------------------------------------	--------------------------------------------

Residential address:
Street:

City/Suburb:	Postcode:	State:
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Contact details: Home phone:	Work phone:
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Mobile:	Email:
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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

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

Do you require an interpreter? No Yes
 If you answered yes, please specify the language:

Are you hearing or sight impaired? No Yes

Do you required help with written or spoken communication? No Yes

Height (in cm):	Weight (in kg):
------------------------	------------------------

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

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

Is there a compensation case relating to this episode? No Yes
 If yes, record the type of compensation: Workers compensation Public liability
 Motor vehicle Other:

How did your main pain begin? (tick **one** box only)

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:

How long has the 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

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 that last less than 6 hours)
 Occassionally present (pain occurs once to several times per day, lasting up to an hour)
 Rarely present (pain occurs every few days or weeks)

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Do you have any of the following medical conditions?

[] 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 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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Section 2 - Your Work

Are you currently employed (working for pay)?

Yes - If yes are you:

Working full-time

Working part-time

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)

Please answer the questions below



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

..... hours

(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)

During the past seven days, how many hours did you actually work?

..... hours

*(If "0", skip the next question and go to **Section 3**)*

During the past seven days, how much did your pain effect your productivity while you were working?

Think about the 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 **pain** affected productivity **while you were working**

Pain had no effect on my work

0 1 2 3 4 5 6 7 8 9 10

Pain completely prevented me from working

Circle a number

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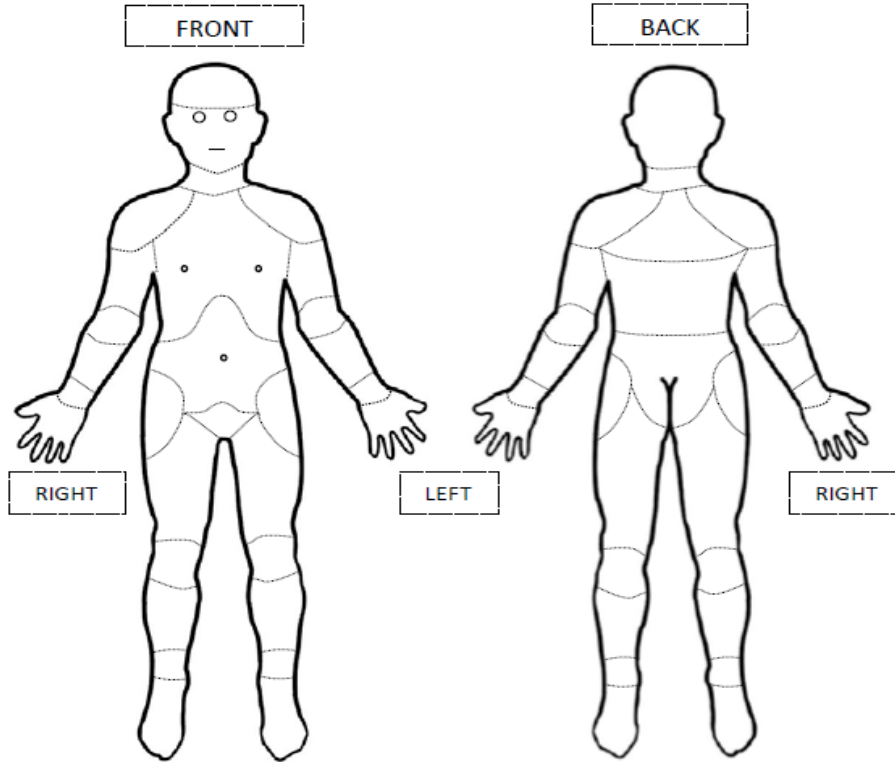
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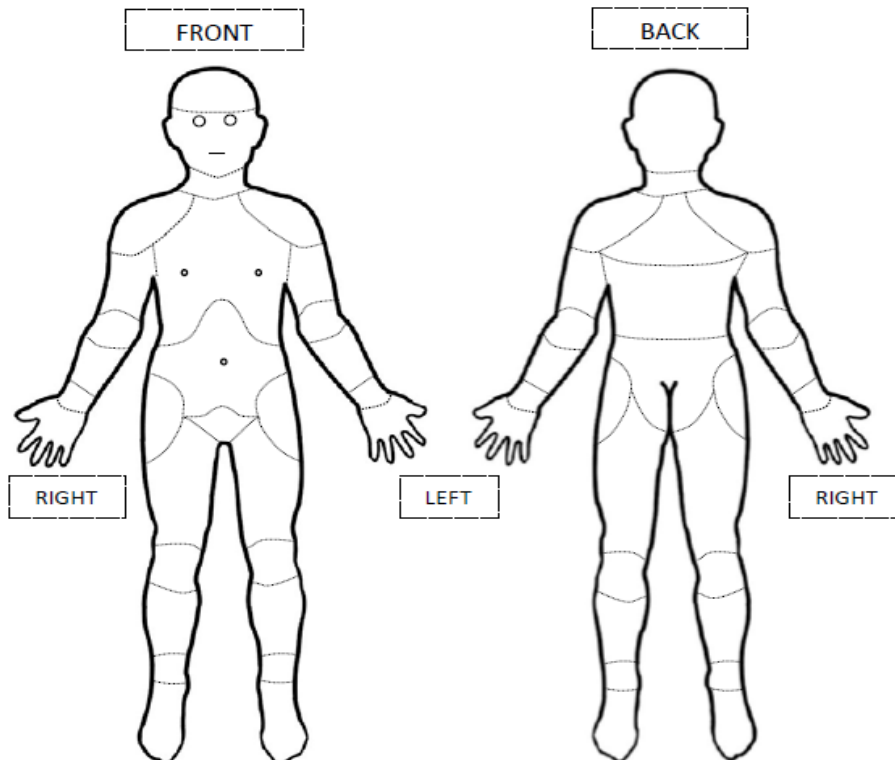
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Section 4 - Pain intensity and interference

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



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



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

1. Your pain at its <i>worst</i> 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 <i>least</i> 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 <i>average</i> ?	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 <i>right now</i> ?	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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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

	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. 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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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**.

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

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Thank you for completing this questionnaire



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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:

- | | | | |
|------------------------------------------|------------------------------------------|------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Opioids | <input type="checkbox"/> Paracetamol | <input type="checkbox"/> NSAIDs | <input type="checkbox"/> Medicinal Cannabinoids |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Anticonvulsants | <input type="checkbox"/> Benzodiazepines | |

Daily oral morphine equivalent:mg

Opioid medication > 2 days/week: Yes No

Opioid replacement / substitution program? Yes No

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Acknowledgements

We acknowledge the 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 acknowledgment 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)