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CONSENT FOR RESEARCH
PAIN CLINIC

CWXX104923A NEW: Dec./11

In order to best understand your chronic pain problem there are a number of methods we use. This begins with some information from your family practitioner who sent your referral; and continues with you providing your story with some background information about yourself, your health and life as well as your pain problem.

The questions and questionnaires you are about to answer help us to begin to understand how you are living with chronic pain. The information you provide will help us to fully asses your pain and work with you when deciding on which treatments would be best for you.

You will complete a single page questionnaire at each visit and may repeat other questionnaires at various times through out the course of your time with us. This will assist us in measuring the benefit of the treatments.

As with all the information within health care, your answers to these questionnaires will be treated as **confidential** and only authorized staff at the JPOCSC Pain Clinic will have access to them.

RESEARCH.

Our clinic participates in research projects as do many others in the world. This research helps health care providers to improve their understanding of pain and its effects on people's lives.

Any information used for our research has personal details (name, address, date of birth) removed to protect your privacy.

If you do not wish the information you provide to be used for research purposes, you are entitled to say so and this will not affect your rights or your medical care at the JPOCSC Pain Clinic.

I confirm that:

☐ **YES** I consent to allow my data to be used for research

☐ **NO** I am **not** consenting to allow my data to be used for research

Signature of patient

Date

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INTAKE FORM
PAIN CLINIC

Date: ______________ Name: ______________________________

Email Address: (to send education information only) ______________________________

As part of our assessment of your pain problem, we need some background information on you and your general health as well as your pain.

Person providing the Information: ☐ Self ☐ Spouse ☐ Child _______ ☐ Other ___________

☐ Interpreter ______________ Language spoken ______________________

Is this visit related to: ☐ WCB ☐ ICBC ☐ legal case ☐ future legal claim ☐ none

Claim/Case# ______________________

What was your main occupation before your pain/injury?

____

Have you previously attended a pain specialist or pain clinic?

☐ No ☐ Yes Please provide details (when where and what treatments for example)

____

____

____

Please describe the course of your pain (how and when it began)

____

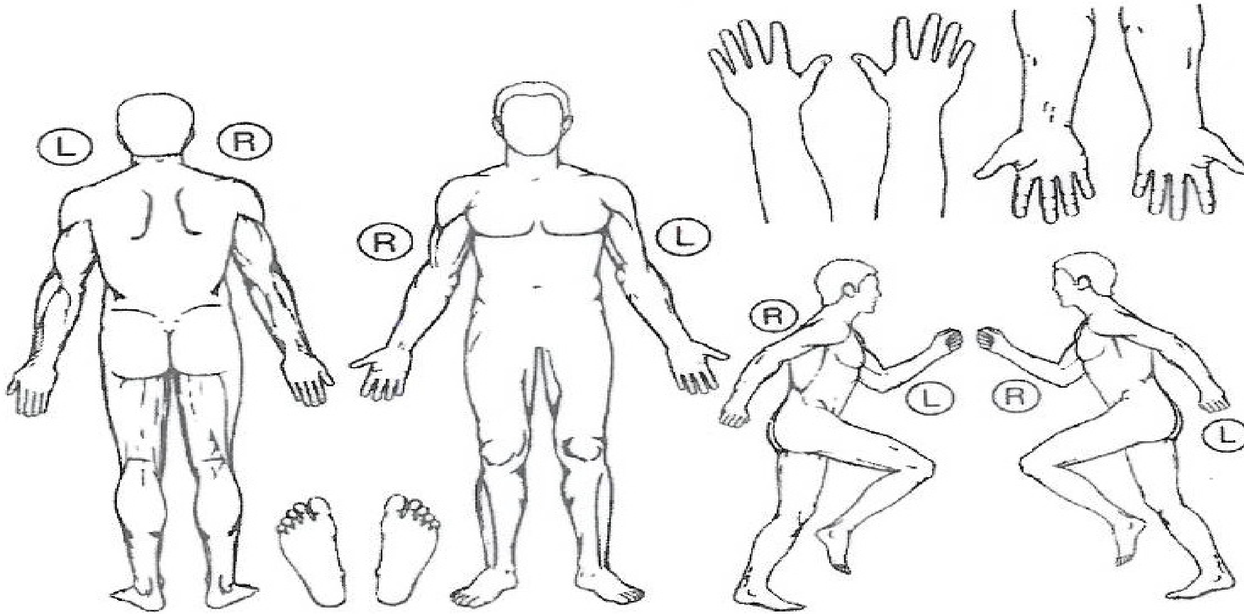
____

____

____

Mark the picture that best describes the course of your pain:		yes	comments
	Persistent pain with slight fluctuations		
	Persistent pain with pain attacks		
	Persistent pain without pain between them		
	Persistent pain with pain between them		

On the diagram below, indicate the areas where you feel pain using the letters or the colours indicated below



S =	sharp/stabbing	PURPLE	A=	ORANGE	aching
N =	numbness	BLUE	B=	RED/PINK	burning
P =	pins + needles	GREEN	X=	BLACK	OTHER:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Moderate — Worst Pain

Please rate your pain over the last week using the 0 - 10 scale (0 = no pain, 10 = worst pain).

	Area	Worst	Best	Average	Now	Comments
1						
2						
3						

We would like to know how much your pain is preventing you from doing what you would normally do or from doing it as well as you normally would.

Respond to each category by indicating the overall impact of pain in your life, **not just when the pain is at its worst.**

A score of 0 means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been prevented by your pain.

Family/home responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (eg, yard work) and errands or favors for other family members (eg, driving the children to school).

0 1 2 3 4 5 6 7 8 9 10
No disability Worst disability

Recreation: This category includes hobbies, sports, and other similar leisure-time activities.

0 1 2 3 4 5 6 7 8 9 10
No disability Worst disability

Social activity: This category refers to activites that involve participation with friends and acquaintances other than family members. It includes parties, theatre, concerts, dining out, and other social functions.

0 1 2 3 4 5 6 7 8 9 10
No disability Worst disability

Occupation: This category refers to activities that are a part of or directly related to one's job. This includes non-paying jobs as well, such that of a homemaker or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10
No disability Worst disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

0 1 2 3 4 5 6 7 8 9 10
No disability Worst disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (eg, taking a shower, driving, getting dressed, etc.)

0 1 2 3 4 5 6 7 8 9 10
No disability Worst disability

Life-support activity: This category refers to basic life-supporting behaviours such as eating, sleeping and breathing.

0 1 2 3 4 5 6 7 8 9 10
No disability Worst disability

Would any of the pain you are having be described as?

	yes	no		yes	no			
burning			itchy				yes	no
pins & needles			painful cold			Does the area have less feeling or sensation than other areas?		
electric shocks						Does the pain increase when the area is lightly touched or brushed against		

What types of things (treatments/activity) make your pain better or worse?

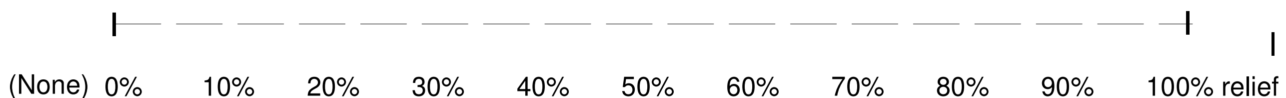
	better	worse		better	worse		better	worse
Heat			Cough			Driving		
Cold			Sneeze			Bending		
Massage			Lying on back			Computer work		
Stretching			Relaxation			Physiotherapy		
Walking			Lifting			Chiropractor		
Sitting			Exercise			Acupuncture		
Changing positions			Lying on stomach			Other:		

What Investigations/treatments have you had, such as:
X-ray, CT, MRI, specialists, psychology, physiotherapy

Treatments Tried and the number of times in last 8 weeks:

Treatment	# of times	Treatment	# of times	Treatment	# of times
General Practitioner		Psychiatrist		Exercise/stretching	
Physiotherapist		Chiropractor		Pool therapy	
Psychologist		Emergency Dept.		Acupuncturist	
Specialist		Surgeon		Naturopath	
Other (specify):					

In the last week how much (%) relief have treatments provided



(None) 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% relief

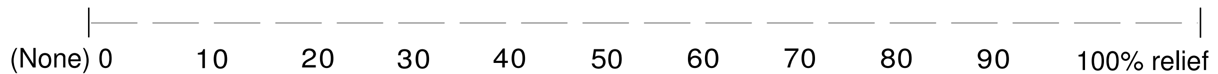
Medications you have tried for pain management:

Medication	Dose	# of times per day	X if still taking	Side effects or Reason for stopping

Please list any allergies (food, medication, environmental) you have and the reactions you get from them:

Allergy	Reaction

In the last week how much (%) relief has your current pain medications provided?



(None) 0 10 20 30 40 50 60 70 80 90 100% relief

Do you think you need more medication than you are currently taking?

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

Do you think you need stronger medication, than you are currently taking?

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

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

Treatment	Never Tried	Helpful	No help	Pain Worse	Ongoing
Surgery					
Nerve blocks					
TENS					
Bed rest in hospital					
Bed rest with traction					
Psychology/psychiatry					
Hypnosis/					
Relaxation					
Acupuncture					
Chiropractic					
Pool therapy					
Physiotherapy (hands on)					

My goals are:

____

____

____

____

____

Your Story

If you wish to, this section is reserved for you to tell ***your*** story. This may be the story of your pain and how it affects you and your lifestyle, or what you do now to limit your pain's effect on your life.

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CURRENT Medications- (prescriptions, over the counter, herbals, vitamins) Name dose and frequency

Name	Dose (MG)	Frequency (how often)	Name	Dose (MG)	Frequency (how often)

Past Health History,

Height ________________ Weight ____________________

Weight changes: ☐ No ☐ Yes → gain/loss _______________ over what period of time ______________

Have you experienced any issues with any of the following? Circle and describe:

Conditions/issues	yes	no	Please describe
Heart, Lung, Blood Pressure, High cholesterol			
Kidney, Diabetes, Thyroid			
Brain, Stroke, Seizures			
Liver, Bowels			
Eye, Ear, Nose, Throat, Face, Skin			
Bladder or Reproductive organs			
OTHER:			
Attention Deficit disorder			
Obsessive Compulsive disorder			
Bipolar disorder /Schizophrenia			
Depression			
History of preadolescent sexual abuse			

INTAKE FORM Cont'd

	yes	no	
Alcohol abuse/ Prescription drug abuse			
Smoke Tobacco ☐ Quit Year _______________			_______pack per day x _____years
Street substances: ☐ Quit Year ___________			Type, route, and frequency of use

Alcohol Consumption

☐ Quit Year _______________

☐ No ________________________________

☐ Yes Approximate # __________ each day / week / month / year

Have you ever felt you should cut down on your drinking?	yes	no
Have people annoyed you by criticizing your drinking?	yes	no
Have you ever felt bad or guilty about your drinking?	yes	no
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?	yes	no

Surgeries/operations and other conditions (please list)

____

____

____

Caffeine: (amount/day e.g. coffee, tea, cola, chocolate, etc) ________________________

Exercise: (type, frequency/wk, for how long) ____________________________

Sleep: Usual bedtime ____________ Usual rising time ___________

Number of times pain disturbs your sleep (on average) each night? ________________

What do you do to return to sleep? ______________________________

Do you live in a ☐ house / ☐ condo / ☐ apartment? ☐ Stairs how many ____________

With whom do you live? ☐ Alone ☐ Spouse/partner ☐ children ☐ ______________

Family History (your parents, siblings, grandparents) history of:

	yes	no		yes	no		yes	no
ADD schizophrenia			Diabetes			Cancer		
OCD bipolar			Heart disease			Arthritis		
Depression			High cholesterol			Allergies		
Alcoholism			Stroke			Asthma		
Street drug use			Fibromyalgia			Headaches		
Prescription drug abuse			Other					
High blood pressure								

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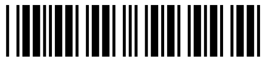
INTAKE FORM - PHQ9
PAIN CLINIC



Over the last <u>2 weeks</u>, how often have you been bothered by **any of the following problems?** (Use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ + ______ + ______ + ________

= Total Score: ________

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
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In these days of high-tech medicine, one of the most important sources of information about you is often missing from your medical records; your own feelings or intuitions about what is happening with your body. We hope that the following information will help to fill the gap. Please answer the following questions according to the scale on the right. Please answer according to your true feelings, not according to what others think you should believe. This is not a test of medical knowledge; we want to know how you see it. Circle the number next to each question that best corresponds to how you feel.

Circle the number next to each question that best corresponds to how you feel.

		Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
1	I'm afraid that I might injure myself if I exercise.	1	2	3	4
2	If I were to try to overcome it, my pain would increase.	1	2	3	4
3	My body is telling me I have something dangerously wrong.	1	2	3	4
4	My pain would probably be relieved if I exercise.	1	2	3	4
5	People aren't taking my medical condition seriously enough.	1	2	3	4
6	My pain/injury/accident has put my body at risk for the rest of my life.	1	2	3	4
7	Pain always means I injured my body.	1	2	3	4
8	Just because something aggravates my pain does not mean it is dangerous.	1	2	3	4
9	I'm afraid that I might injure myself accidentally.	1	2	3	4
10	Simply being careful that I do not make any unnecessary movements is the safest thing I can do to prevent my pain from worsening.	1	2	3	4
11	I wouldn't have this much pain if there wasn't something potentially dangerous going on in my body.	1	2	3	4
12	Although my condition is painful, I would be better off if I were physically active.	1	2	3	4
13	Pain lets me know when to stop exercising so that I don't injure myself.	1	2	3	4
14	It is not really safe for a person with a condition like mine to be physically active.	1	2	3	4
15	I can't do all the things normal people do because it's too easy for me to get injured.	1	2	3	4
16	Even though something is causing me a lot of pain I don't think it is actually dangerous.	1	2	3	4
17	No one should have to exercise when s/he is in pain.	1	2	3	4

(Miller,Kori and Todd, 1991)

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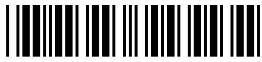
INTAKE FORM - PCS
PAIN CLINIC



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 following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

The rating scale is as follows:
- 0 not at all
- 1 to a slight degree
- 2 to a moderate degree
- 3 to a great degree
- 4 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 that 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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Michael JL Sullivan

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? *(Use "✓" to indicate your answer*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T ____ = ____ + ____ + ____)

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