KAISER PERMANENTE®

Chronic Pain Management
PAIN ASSESSMENT QUESTIONNAIRE

Date: _____

MR # _____

Name: _____

Please answer all of the following questions as best you can. This information will help the Chronic Pain Management Team design a treatment plan for you. All information is kept confidential in your record. Only practitioners providing your care can see it.

Is it hard to read English? ❑Yes ❑ No Is it hard to understand English? ❑ Yes ❑ No

What is the primary language spoken in the home? _____

INFORMATION ABOUT YOUR PRIMARY PAIN PROBLEM

1. What is your main reason/primary diagnosis for coming to the pain clinic today?_____

   _____

2. How long have you had pain? _____

3. Which of the following best describes how the pain began: **Check all that apply.**

   ❑ accident at home ❑ accident at work ❑ work related
   ❑ motor vehicle accident ❑ after surgery ❑ after an illness
   ❑ "just began" ❑ "came on gradually"
   Other:_____

4. How do you best describe your pain?❑ Dull ache ❑ Shooting ❑ Burning ❑ Sharp

   ❑ Throbbing ❑ Other_____

5. Do you have any of the following with your pain?

Tingling/numbness in the hands/feet	❑ Yes	❑ No
Weakness in the hands/feet	❑ Yes	❑ No
Pain radiating/traveling to arm/forearm/hands	❑ Yes	❑ No
Pain radiating/traveling to thigh/buttocks/legs/feet	❑ Yes	❑ No
Dragging the foot while walking	❑ Yes	❑ No
Difficulty holding bladder or bowel movement	❑ Yes	❑ No

6. Do you need to use any of the following to walk or for support since the pain started?

   ❑ Cane ❑ Walker ❑ Crutches ❑ Braces

7. Which affect your pain? **Mark B for better and W for worse.** Leave blank if there is no effect.

___ Massaging or rubbing	__ Coughing	__ Strong emotions	__ Standing
__ Sudden movements	__ Anxiety	__ Getting out of bed	__ Running
__ Noise	__ Heat	__ Sitting	__ Bright light
__ Cold weather	__ Lying down	__ Walking	__ Bending
__ Vibration	__ Ice	__ Physical therapy	__ Straining
__ Wet climate	__ Fatigue	__ Reaching	__ Lifting

   Other_____

TREATMENTS YOU HAVE TRIED

8. Have you had any of the following treatments and what was the result?

Treatment	Facility	When	Result
Acupuncture			

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NAME:_____ **MR:**_____ **Date:** _____

Treatment	Facility	When	Result
Biofeedback			
Braces			
Casting			
Exercise			
Herbal remedies			
Hypnosis			
Medications			
Nerve block/epidural			
Physical therapy			
Psychotherapy			
Relaxation training			
TENS Unit			
Traction			
Other:			

9. List any surgical procedures that you have had to relieve pain. **Use separate sheet if needed.**

Procedure	Facility	When	Result

10. Have you ever attended a Chronic Pain Management Program? ❑ Yes ❑ No

Where?_____ When?_____(year)

INFORMATION ABOUT YOUR MEDICAL HISTORY

11. Please check any of the following that you have had within the last **6 MONTHS**:

❑ Anxiety attack ❑ Feeling tired/low energy ❑ Painful sex/intercourse
❑ Back pain ❑ Headaches ❑ Racing/pounding heart
❑ Bloated/gassy feeling ❑ Joint problems ❑ Seizures
❑ Chest pain ❑ Loss of consciousness ❑ Shortness of breath
❑ Diarrhea or constipation ❑ Low mood ❑ Sleep problems
❑ Dizziness ❑ Memory loss ❑ Trouble walking
❑ Easy bleeding ❑ Nausea/vomiting ❑ Vision change
❑ Fainting spells/blackouts ❑ Painful menstruation ❑ Other: _____

12. Have you ever received mental health treatment? ❑ Yes ❑ No

If yes**, WHEN** and for **WHAT CONDITION**?_____

_____

_____

13. Do you have any blood relatives (immediate family) with a history of any of the following:

❑ Alcoholism/drug abuse ❑ Depression ❑ Headache ❑ Suicide
❑ Chronic pain ❑ Disability ❑ Mental illness
❑ Other medical concern (please specify) _____

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NAME:_____ **MR:**_____ **Date:** _____

INFORMATION ABOUT YOUR MEDICATIONS

14. **PRESENT MEDICATIONS**: List all prescribed and over-the-counter medications (Tylenol, aspirin, etc.) nutritional supplements, herbal remedies, and homeopathic remedies you are currently taking. **Please include medications for pain, sleep, chronic conditions, etc**.

Medication	Dosage / day	Side effects (if any)	How effective

15. **PAST**: List medications (include over-the-counter, herbal and homeopathic) **taken in the past.**

Medication	Dosage / day	Side effects (if any)	Why discontinued?

Use additional sheet of paper if you need more space to answer pain medication questions.

INFORMATION ABOUT YOURSELF

16. Who are you currently living with? (Check as many as apply)
    ❑ Live alone ❑ Spouse/partner ❑ Parents ❑ Roommate ❑ Children, ages_____

17. Describe your home situation (who does most of the chores, stressful home life, satisfaction)

    _____

    _____

    _____

18. Are you currently experiencing any stressful situations? (Check the box for Yes or No).

Marital /relationship stress	❑ Yes	❑ No
Stress at work	❑ Yes	❑ No
Financial stress	❑ Yes	❑ No
Stress with your family	❑ Yes	❑ No
Stress with your friends	❑ Yes	❑ No

19. Do you receive any of the following?

		Related to pain condition?
❑ SDI (State Disability Insurance)	❑ Yes	❑ No
❑ SSI (Supplementary Security Income)	❑ Yes	❑ No
❑ Workers' compensation	❑ Yes	❑ No
❑ Unemployment insurance	❑ Yes	❑ No

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NAME:_____ **MR:**_____ **Date:** _____

20. Is there any Workers' compensation claim or litigation involved with your case?
    - ❑ No
    - ❑ No, but claim or litigation is being considered.
    - ❑ Yes, but already settled. Date: _____
    - ❑ Yes, currently involved.

INFORMATION ABOUT YOUR HABITS

21. **In a typical week**, how many days do you get exercise? _____ **days**
22. **In a typical week**, how many days do you drink alcohol? _____**days**
23. **In a typical day**, how many drinks do you have? _____ (number of drinks).
    (1 drink = 12 ounce can of beer, 4 ounces of wine, or a 1 ounce shot of hard liquor).
24. Have people upset you by criticizing your drinking or other drug use? ❑ Yes ❑ No
25. Have you ever felt you ought to cut down on your drinking or drug use? ❑ Yes ❑ No
26. Have you ever participated in a substance abuse treatment program? ❑ Yes ❑ No
27. Do you use tobacco? (cigarettes, cigars, chewing tobacco, pipe, nicotine replacement)
    ❑Yes ❑ No If Yes, amount per day _____ Number of years _____
28. Do you drink regular coffee, tea, colas or other caffeinated drinks? ❑ Yes ❑ No
    If yes, how much per day? _____(number of drinks) _____ (ounces/drink)
29. Do you use street drugs or drugs not prescribed by your doctor? ❑ Yes ❑ No
    ❑ marijuana ❑ cocaine ❑ methamphetamine ❑ heroin ❑other_____

INFORMATION ABOUT YOUR SLEEP

30. Trouble falling asleep because of pain? ❑ Never ❑ 1-2 times/wk ❑ 3-5 times/wk ❑ 6-7 times/wk
    Wake up in the night because of pain? ❑ Never ❑ 1-2 times/wk ❑ 3-5 times/wk ❑ 6-7 times/wk
    How long does it take to return to sleep? _____
    Need medications to sleep? ❑ Never ❑ 1-2 times/wk ❑ 3-5 times/wk ❑ 6-7 times/wk
    What sleep medications do you take? (include over-the-counter medications) _____

    ___ _____

31. In general, how many hours of sleep do you get per night? _____ hours
32. How many hours of sleep do you need to feel rested? _____hours
33. Do you take daytime naps? ❑ Yes ❑ No

CONCLUSION

Did you fill out this form? ❑Yes ❑ No Did someone help you? ❑ Yes ❑ No

Additional comments or more information about current or past pain medications, pain treatments or surgical procedures for pain:_____

_____

_____

_____

_____

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BRIEF PAIN INVENTORY

Chronic Pain Care Management

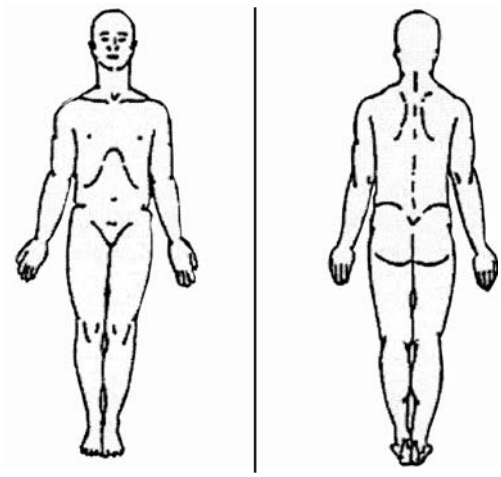
Date ____ / ____ / _____ MR# _____

Name: _____ _____ _____
Last First M. I.

1: Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

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



3: Please rate your pain by circling the one number that best describes your pain at its WORST in the last week.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

4: Please rate your pain by circling the one number that best describes your pain at its LEAST in the last week.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

5: Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

6: Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

7: What treatments or medications are you receiving for your pain?

_____
_____

8: In the last week, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much RELIEF you have received.

0% 10 20 30 40 50 60 70 80 90 100%

9: Circle the one number that describes how, during the past week, pain has interfered with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

D. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

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NAME:_____ **MR:**_____ **Date:** _____

WPAI QUESTIONNAIRE

1. Are you currently employed (working for pay)? _____ NO ___ YES
   If NO, check "NO" and skip to question 7.
2. Please choose the category that best describes your main job.

   ❑ Executive ❑ Professional ❑ Technical support ❑ Sales ❑ Clerical
   ❑ Service occupation ❑ Precision production & crafts ❑ Operator/laborer
3. During the past 4 weeks, how many hours did you miss from work because of problems your health problems? *Include hours you missed on sick days, times you went in late, left early, etc., because of your health problems. Do not include time you missed to participate in this program.*
   _____ HOURS
4. During the 4 weeks, how many hours did you miss from work because of any other reason, such as vacation, or holidays?
   _____HOURS
5. During the past 4 weeks, how many hours did you actually work?
   _____HOURS *(If "0", skip to question 7)*
6. During the past 4 weeks, how much did your health problems affect 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 health problems affected your work only a little, choose a low number. Choose a high number if health problems affected your work a great deal.

   PROBLEM had no effect on my work 0 1 2 3 4 5 6 7 8 9 10 PROBLEM completely prevented me from working

   CIRCLE A NUMBER
7. During the past 4 weeks, how much did your health problems affect your ability to do your regular daily activities, other than work at a job?

   By regular activities, we mean the usual activities you do, such as work around the house, shopping, childcare, exercising, studying, etc. Think about times you were limited in the amount or kind of activities you could do and times you accomplished less than you would like. ***If health problems affected your activities only a little, choose a low number. Choose a high number if health problems affected your activities a great deal.***

   PROBLEM had no effect on my daily activities 0 1 2 3 4 5 6 7 8 9 10 PROBLEM completely prevented me from doing my daily activities

   CIRCLE A NUMBER

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MR # _____

NAME: _____ **DATE:** _____

Over the *last 2 weeks,* 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
add columns:		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**				

10. If you checked off *any* problems, how *difficult* 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** _____

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02015-009 (9-10)

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MR # _____

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Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
5. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

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