

Date of filling out Questionnaire _____

Last Name _____ **First Names** _____

How do you like to be called _____

Street Address _____

Town _____ **Post Code** _____

Phone () _____ **Mobile** _____

Date of Birth _____ Female Male **NHI Number** _____

Age _____ **Height** _____ (cm) **Weight** _____ (kg)

Email address _____

Are you happy for us to email you your letters? Yes No

Please list the names and mailing addresses of all Health Care Professionals involved in your care (incl. GPO, Specialists, Physiotherapists, Chiropractors, etc.):

1. _____

2. _____

3. _____

4. _____

5. _____

Funding of Pain consult

Private Insurance: _____ Approval number _____

ACC: Date of Accident _____ Claim number _____
Case Manager _____ ACC Branch _____

Other _____

Marital Status (at present)

- Single / Never married Married; how long _____
 Widowed Separated / Divorced

Number of children _____

With whom are you currently living ?

- Alone Parent Spouse Others
Children _____ How many live with you ? _____

Current Occupation (specify titles)

Current Employer _____

How many hours do you work per week _____

If you are not working, please tell us your previous occupation

Occupation of Spouse _____

Ethnic Group (we are obliged to collect this data)

- NZ Maori NZ European Chinese Indian Asian
 European Which country ? _____
 Other _____

What **language** do you usually speak ?

- English Maori Other _____

If non-English speaking or deaf, do you need an **interpreter** ? Yes No

Do you require a **support person** to attend your appointments ? Yes No

Please comment _____

Do you require **assistance with transport** to attend your appointments ? Yes No

Please comment _____

Please let us know **which of the following locations** is preferable to you to see Dr. Neff

- 17 Marguerita Street, Rotorua
 7 Thakeray Street, Hamilton (Anglesea Sports & Physiotherapy Clinic)

Please mark each of the following

- Is your age over 50 and under 20 Yes No _____
- Have you ever been diagnosed with cancer Yes No _____
- Have you suffered recently from chills or fevers Yes No _____
- Have you recently lost weight unexpectedly Yes No _____
- Have you had a recent bacterial infection Yes No _____
- Have you ever used intravenous drugs for recreation Yes No _____
- Have you ever had an organ transplant Yes No _____
- Have you taken steroids in the last 12 months ? Yes No _____
- Have you ever been diagnosed with HIV / AIDS Yes No _____
- Have you recently had an accident
(a fall from height, vehicle accident, etc) ? Yes No _____
- Have you suffered from minor trauma (even strenuous lifting) Yes No _____
- Have you lost sensation between your legs ? Yes No _____
- Have you recently had problems with your bladder (e.g. retention, increased frequency, or overflow incontinence) ? Yes No _____

Please tell me more about your pain !

What is the main problem for which you are seeking help?

Have you got any other pains ? 1 2 3 4 > 4

Which pain bothers you most ? _____

How did the pain start ? _____

How long have you had this pain ? _____ months

Has the type of pain changed over time ? No Yes, How _____

Has the severity changed? Better over time Unchanged Worse

Do you know the cause of your pain ? _____

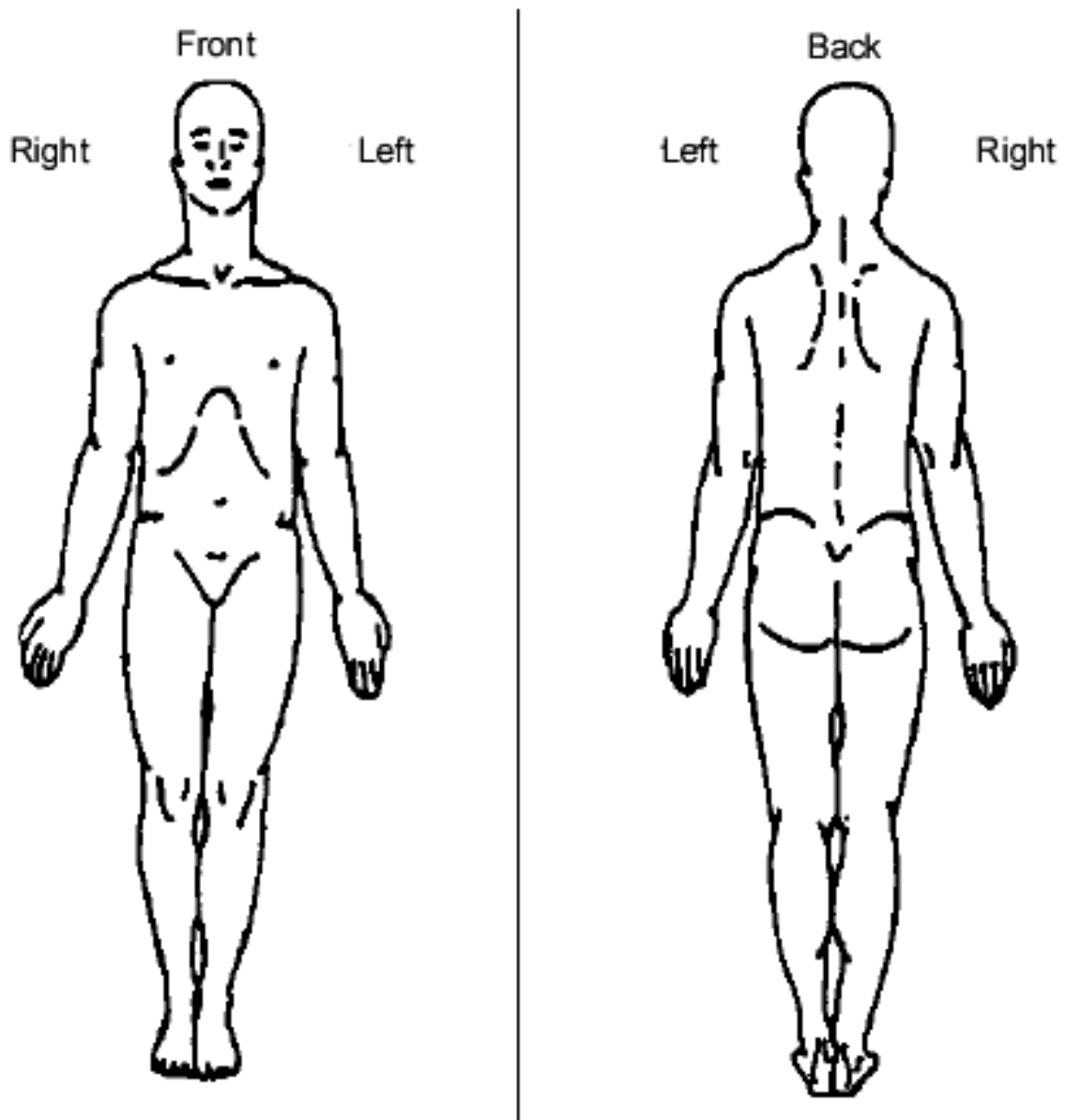
On the diagram, shade in the areas where you feel pain

Put an X on the area that hurts most

Add the letter "I" for Internal Pain (deep inside)

"E" for External Pain (skin level)

"IE" for pain that feels deep inside and at the skin level



How often do you have your pain (please check one)

- Constantly (100 % of the time)
- Nearly constantly (60-95 % of the time)
- Intermittently (30-60 % of the time)
- Occasionally (less than 30 % of the time)

In general, during the past month **when has your pain been the worst** (please check one)?

- Morning
- Afternoon
- Evening
- Night
- No typical pattern

For each pain you are suffering please indicate the following

(Please use different colours or mark differently for each pain)

Please rate your pain by circling the one number that best describes your pain at its **worst** in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10

(No pain)

(Pain as bad as you can imagine)

Please rate your pain by circling the one number that best describes your pain at its **least** in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain by circling the one number that best describes your pain **on average**.

0 1 2 3 4 5 6 7 8 9 10

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

Please tell me how closely each of these words describe your pain. Please mark each word below ! If you suffer from multiple pains – use different colour to describe each pain in itself !

	None	Mild	Moderate	Severe
Throbbing	_____	_____	_____	_____
Shooting	_____	_____	_____	_____
Stabbing	_____	_____	_____	_____
Sharp	_____	_____	_____	_____
Cramping	_____	_____	_____	_____
Gnawing	_____	_____	_____	_____
Hot-burning	_____	_____	_____	_____
Aching	_____	_____	_____	_____
Heavy	_____	_____	_____	_____
Tender	_____	_____	_____	_____
Splitting	_____	_____	_____	_____
Tiring-exhausting	_____	_____	_____	_____
Sickening	_____	_____	_____	_____
Fearful	_____	_____	_____	_____
Punishing-cruel	_____	_____	_____	_____

How do the following affect your pain (please check one for each item)? (Use different colours if you are suffering from multiple pains)

	Makes it better	No effect	Makes it worse
Lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relaxation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinking about something else	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/ Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Passing water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does your pain feel like strange, unpleasant sensations in your skin ? Words like pricking, tingling, pins, and needles might describe these sensations (please tell us more about those sensations including where you can feel those sensations)

No Yes _____

Does your pain make the skin in the painful area look different from normal ? Words like mottled or looking more red or pink might describe the appearance. (please describe)

No Yes _____

Does your pain make the affected skin abnormally sensitive to touch ? Getting unpleasant sensations when lightly stroking the skin or getting pain when wearing tight clothes might describe the abnormal sensitivity. (please describe)

No Yes _____

Does your pain come on suddenly and in bursts for no apparent reasons when you're still? Words like electric shocks, jumping and bursting describe these features. (please describe)

No Yes _____

Does your pain feel as if the skin temperature in the painful area has changed abnormally ? Words like hot, burning and freezing might describe these sensations. (please describe)

No Yes _____

Does your affected area sweat differently? Either more or less compared with the other side

No Yes _____

Do muscles in the affected area at times move without your control? (Flickering of muscles under the skin, tendency to drop things, leg giving way, etc.)

No Yes _____

How does the pain affect your function ? (Continuously at one time)

How long can you sit? _____ minutes

How long can you stand? _____ minutes

How long can you walk? _____ minutes

Can you bend or twist your back ? Yes Yes but painful No

Can you squat? Yes Yes but painful No

Repetitive movements with your arms

Can you write? Yes Painful _____ minutes Not at all

Keyboarding? Yes Painful _____ minutes Not at all

Using hand tools? Yes Painful _____ minutes Not at all

Driving a car? Yes Painful _____ minutes Not at all

Comments _____

During the past month, how much did pain interfere with the following activities

	Not at all	Extremely
Going to work	_____	
Household chores	_____	
Going shopping	_____	
Socialising with friends	_____	
Participating in recreation	_____	
Having sexual relations	_____	
Physically exercising	_____	
Eating	_____	

Have you got difficulties going to sleep ? No Yes _____

How many hours do you sleep on a typical night ? _____ hrs

How many times are you woken by pain on a typical night ? _____

Do you snore ? _____

Have you been told that you stop breathing during the night for some seconds ? _____

Do you ever fall asleep in places where you don't want to (GP surgery, etc) _____

How often during the day do you lie down because of the pain ? _____

How many hours would you spend lying down during the day ? _____ hours

What do you do if the pain gets really bad ? How do you cope ?

Please tick any of the following coping mechanisms if you use it regularly for your pain

Meditation	<input type="checkbox"/>	Pacing	<input type="checkbox"/>	Goal-Setting	<input type="checkbox"/>
Distraction	<input type="checkbox"/>	Relaxation	<input type="checkbox"/>	_____	<input type="checkbox"/>

List 4 activities / goals you would like to achieve if your pain level is improved. How much does your pain interfere with these activities right now (Please mark on the line below)

Your Goal	Not at all	Extremely
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any further comments with regards to your pain ?

Please check all of the **pain treatments** you have tried for your pain, and complete the appropriate columns at the right ?

	Treatment	When	Helpful	Not helpful
Hospital Bed rest				
Traction				
Surgery				
Hypnosis				
Acupuncture				
Nerve Block or injection				
TENS				
Physiotherapy				
Exercise				
Heat Treatment				
Biofeedback				
Psychotherapy				
Chiropractic				

Please list all **pain medications you have taken in the past** for this painful condition and tell us why you have stopped them ?

Name of Drug	Maximum dose	How many times a day	Did it make the pain better	Side Effects

Please continue on the backside of this sheet if you have trialled any other medications or pain management techniques.

When you are in pain, how often is your husband / wife / other family member supportive and encouraging ?

- Never
- Seldom
- Sometimes
- Frequently
- Always

When you are in pain, how often does your husband / wife / other family member ignore you or become angry ?

- Never
- Seldom
- Sometimes
- Frequently
- Always

How often has there been disharmony / conflict between you and your spouse, parent or children since the start of your pain ?

- Never
- Seldom
- Sometimes
- Frequently
- Always

Have any of your family members ever had a chronic pain problem ?

- Yes
- No If yes, who ? _____

What kind of pain ? _____

Have you ever experienced any physical, emotional or sexual abuse ?

- Yes
- No If yes, explain _____

Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain ?

- Yes
- No If yes, what and when ? _____

In the last 3 months: Have you ever had thoughts of harming yourself to stop the pain?

- Yes
- No

If yes, who do you turn to in order to get help? _____

How many standard drinks do you enjoy per day / week

- None
- I do enjoy _____ drinks per week

How many cigarettes do you smoke / day ?

- None
- I do smoke _____ cigarettes / day

Do you take any recreational drugs ?

- None
- Yes, I take _____

Have you ever smoked marijuana for your pain?

- None
- Yes Has it reduced the pain ?
- No
- Yes

Over the last 2 weeks, how often have you been bothered by any of the following problems
 Mark the appropriate answer for question (1 answer per statement)

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down.				
Trouble concentrating on things, such as reading a newspaper or watching television				
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				
Thoughts that you would be better off dead, or of hurting yourself in some way				

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

Functional Status

- Independent
 Difficulty with balance
 Recent history of falls
 Need home help
 Live in nursing home
 Live in Hospice

Disabilities or impairments

- None
 Vision
 Hearing
 Mobility
 I need a wheelchair to move around

Other _____

**The following are questions given to all patients at the Pain Management Clinic.
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.**

Please answer the following questions using the following scale:

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

- | | | | | | |
|--|---|---|---|---|---|
| 1. How often do you feel that your pain is “out of control?” | 0 | 1 | 2 | 3 | 4 |
| 2. How often do you have mood swings? | 0 | 1 | 2 | 3 | 4 |
| 3. How often do you do things that you later regret? | 0 | 1 | 2 | 3 | 4 |
| 4. How often has your family been supportive and encouraging? | 0 | 1 | 2 | 3 | 4 |
| 5. How often have others told you that you have a bad temper? | 0 | 1 | 2 | 3 | 4 |
| 6. Compared with other people, how often have you been in a car accident? | 0 | 1 | 2 | 3 | 4 |
| 7. How often do you smoke a cigarette within an hour after you wake up? | 0 | 1 | 2 | 3 | 4 |
| 8. How often have you felt a need for higher doses of medication to treat your pain? | 0 | 1 | 2 | 3 | 4 |
| 9. How often do you take more medication than you are supposed to? | 0 | 1 | 2 | 3 | 4 |
| 10. How often have any of your family members, including parents
and grandparents, had a problem with alcohol or drugs? | 0 | 1 | 2 | 3 | 4 |
| 11. How often have any of your close friends had a problem with alcohol or drugs? | 0 | 1 | 2 | 3 | 4 |
| 12. How often have others suggested that you have a drug or alcohol problem? | 0 | 1 | 2 | 3 | 4 |
| 13. How often have you attended an AA or NA meeting? | 0 | 1 | 2 | 3 | 4 |

Many People experience pain, Fatigue (i.e. feeling tired), emotional distress (e.g. worries, feeling sad) and interference with daily activities (e.g. not being able to work or do household chores) as a result of their medical condition. We would like to understand how you have been impacted in each of these areas. We would also like to learn more about what you want your treatment to do for you.

Firstly, we would like to know your usual levels of pain, fatigue, emotional distress and interference.

On a scale of 0 (none) to 10 (worst imaginable), please indicate your usual level (during the past week) of

- Pain _____
- Fatigue _____
- Emotional distress _____
- Interference with daily activities _____

Now, we would like to learn about you desired levels of pain, fatigue, emotional distress and interference. In other words, we would like to understand what your ideal treatment outcome would be.

On a scale of **0 (none) to 10 (worst imaginable)**, please indicate your desired level of

- Pain _____
- Fatigue _____
- Emotional distress _____
- Interference with daily activities _____

Patients understandably want their treatment to result in desired or ideal treatment outcomes like you indicated above. Unfortunately, available treatments do not always produce desired outcomes. Therefore, it is important for us to understand what treatment outcomes you would consider successful.

On a scale of **0 (none) to 10 (worst imaginable)**, please indicate the level each of these areas would have to be at for you to consider treatment successful.

- Pain _____
- Fatigue _____
- Emotional distress _____
- Interference with daily activities _____

Please add any further information regarding your pain / yourself which has not yet been discussed.

What to do now ?

1. Please return the completed questionnaire to:
Rotorua Pain Specialists Ltd; PO. Box 12083, Rotorua
Alternatively fax the questionnaire to 07 3459921
2. If you are an ACC client please assure that your case manager has approved the consultation and treatment.
3. Please make an appointment with my PA Brigid Gray
by calling 07 – 3459915
via email Brigid.Gray@painspecialists.co.nz
4. Please bring all available Xrays, letters and medical reports to your appointment
5. We will contact your GP and request that she/he sends us all information with regards to your current medications, recent blood tests as well as other health problems that may affect and alter the way we can help you managing your pain.

Thank you for your patience !

I am looking forward to meeting you in the near future !