

**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     NoDo 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 \_\_\_\_\_

**Headache History**

**Onset:** How old were you when you had your first significant headache?

\_\_\_\_\_ yrs

**Frequency:** Over the past 2 months, how many individual headache attacks have you averaged per month? \_\_\_\_\_

**Duration:** How long does a typical headache attack last?

- 0-1 hr     1-6 hr     6-12 hr     12-24 hr     24-48 hr
- > 48 - 72 hr     >72 hr     constant     too variable

**Change:** Has there been any recent change in the character or frequency of your headaches?

No  Yes; please specify what type of change: \_\_\_\_\_

**Triggers:** Check any of the following factors which seem to trigger a headache attack in you:

- Alcohol (specify types): \_\_\_\_\_
- Menstruation     Emotional stress     Odors (please list: ) \_\_\_\_\_
- Fatigue     Missing meals     caffeine     changes in weather
- Other \_\_\_\_\_

How would you describe your headache to friend ? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are your headaches ever incapacitating (e.g., have to leave work or lie down undisturbed)?

No  Yes

How many days per month are you incapacitated by headache? \_\_\_\_\_

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

Overall, how disabled do you feel you have been by headaches over the past 2 months?

0    1    2    3    4    5    6    7    8    9    10

Not troubled at all

Completely incapacitated

Is your headache pain ever throbbing?  No  Yes  Unknown

If yes, what percent of your headache attacks involve "throbbing" pain? \_\_\_\_\_%  unknown

Is your headache ever localised to one side? \_\_\_\_\_%  unknown

Does your headache typically occur at a certain time of day or on certain week days of the week or month?  No  Yes (If yes, please describe ) \_\_\_\_\_

Do you have any warning symptoms which alert you that you are going to have a headache attack?  No  Yes (If yes, what type of warning do you have?)

Do you ever experience any of the following **symptoms** in association with your headache attacks (before, during, or after)? Please check the appropriate boxes:

- nasal congestion                       diarrhea
- nausea (with what % of attacks do you experience nausea? \_\_\_\_\_%     unknown
- vomiting (with what % of attacks do you experience vomiting? \_\_\_\_\_%     unknown
- visual changes (e.g.s, visual distortion, "flash cubes", "zig-zags", "blind spots", "sparkles").

(Please describe: ) \_\_\_\_\_

- Diarrhoea
- Inability to tolerate bright light (photophobia)
- Inability to tolerate loud noise (phonophobia)
- Numbness and/or tingling in face, arm, or leg (Please describe: ) \_\_\_\_\_

Speech disturbance (Please describe: ) \_\_\_\_\_

- Loss of balance
- Vertigo (i.e., a spinning/"merry-go-around" sensation)
- Extreme thirst, food cravings (Please describe: ) \_\_\_\_\_

**What makes your headache worse** \_\_\_\_\_

\_\_\_\_\_

**What makes your headache better** \_\_\_\_\_

\_\_\_\_\_

Do you consider yourself to be currently under a significant amount of stress?     No     Yes

Do you adhere to a regular exercise program?     No     Yes

Do you eat at regular intervals?     No     Yes

Have you taken oral contraceptives / oestrogen replacement therapy in the past?     No     Yes

(If yes, effect on your headaches?     Better     worse     no change     can't recall

Have you been pregnant?     No     Yes

(If yes, effect on your headaches?     Better     worse     no change     can't recall

Have you seen a doctor in the past for your headaches?  No  Yes

His/Her diagnosis (if known): \_\_\_\_\_

Have you had a CT scan in the past?  No  Yes  Unknown

Have you had a brain MRI scan in the past?  No  Yes  Unknown

**Other pains in addition to your headache**

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

If you do not suffer from any other pains please go to Page 10 to the chapter "Sleep"

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Which pain bothers you most ? \_\_\_\_\_

How did the pain start ? \_\_\_\_\_

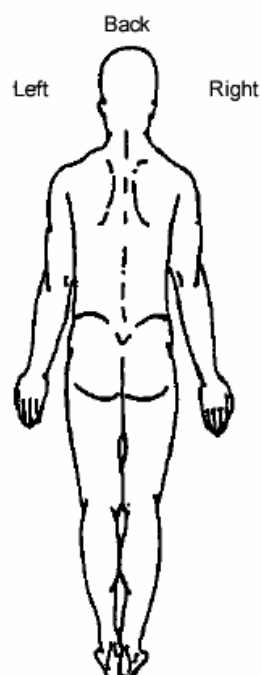
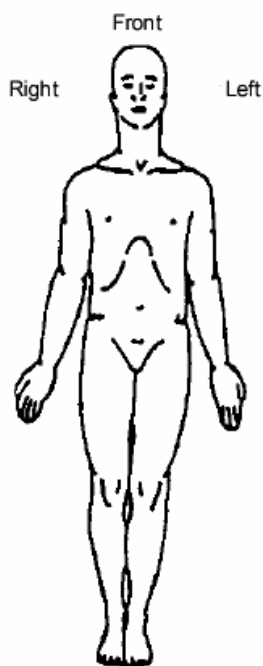
How long have you had this pain ? \_\_\_\_\_ months

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

Has the severity changed?  Better over time  Unchanged  Worse

**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 (**apart from headaches**) 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
<b>Throbbing</b>	_____	_____	_____	_____
<b>Shooting</b>	_____	_____	_____	_____
<b>Stabbing</b>	_____	_____	_____	_____
<b>Sharp</b>	_____	_____	_____	_____
<b>Cramping</b>	_____	_____	_____	_____
<b>Gnawing</b>	_____	_____	_____	_____
<b>Hot-burning</b>	_____	_____	_____	_____
<b>Aching</b>	_____	_____	_____	_____
<b>Heavy</b>	_____	_____	_____	_____
<b>Tender</b>	_____	_____	_____	_____
<b>Splitting</b>	_____	_____	_____	_____
<b>Tiring-exhausting</b>	_____	_____	_____	_____
<b>Sickening</b>	_____	_____	_____	_____
<b>Fearful</b>	_____	_____	_____	_____
<b>Punishing-cruel</b>	_____	_____	_____	_____

**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 \_\_\_\_\_

**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**

(Please mark along each of the lines)

	Not at all	A little bit	Moderately	Quite a bit	Extremely
Going to work	_____				
Household chores	_____				
Going shopping	_____				
Socialising with friends	_____				
Participating in recreation	_____				
Having sexual relations	_____				
Physically exercising	_____				
Eating	_____				

**Sleep**

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"/> |



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.

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
Surgery				
Hypnosis				
Acupuncture				
Nerve Block or injection				
TENS				
Physiotherapy				
Exercise				
Heat Treatment				
Biofeedback				
Psychotherapy				
Chiropractic				

**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?**

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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)

	<b>Not at all</b>	<b>Several days</b>	<b>More than half the days</b>	<b>Nearly every day</b>
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 \_\_\_\_\_

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**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<br>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.**

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**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. Only because you are under ACC may not mean that ACC will pay our fee!
3. Please make an appointment with Brigid Gray  
by calling 07 – 3459915 or  
via email [Brigid.Gray@painspecialists.co.nz](mailto: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 !**