

**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 ? \_\_\_\_\_ What is their age? \_\_\_\_\_

**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

- Southern Cross Hospital, Rotorua  
 7 Thakeray Street, Hamilton (Anglesea Sports & Physiotherapy Clinic)  
 27-28 Douglas McLean Ave, Marewa, Napier (Central Medical)

**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

**Please bring any copies of the CT / MRI reports in your possession!**

**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 ? \_\_\_\_\_

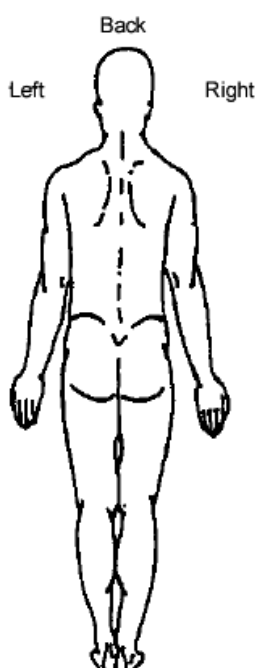
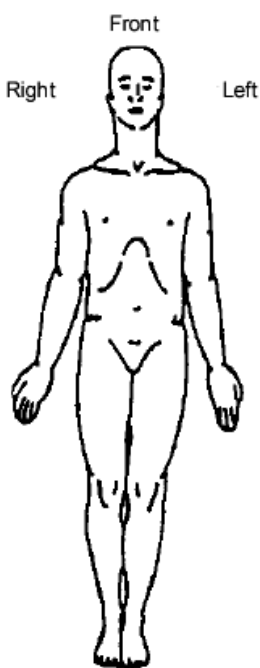
How long have you had this pain ? \_\_\_\_\_ months

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 does the pain interfere with your life ?**

**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	_____	
How long can you sit?	_____ minutes	
How long can you stand?	_____ minutes	
How far can you walk?	_____ metres	
Can you bend or twist your back ?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes but painful <input type="checkbox"/> No	
Can you squat?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes but painful <input type="checkbox"/> No	

**Repetitive movements with your arms**

Can you write?	<input type="checkbox"/> Yes	<input type="checkbox"/> Painful _____ minutes	<input type="checkbox"/> Not at all
Keyboarding?	<input type="checkbox"/> Yes	<input type="checkbox"/> Painful _____ minutes	<input type="checkbox"/> Not at all
Using hand tools?	<input type="checkbox"/> Yes	<input type="checkbox"/> Painful _____ minutes	<input type="checkbox"/> Not at all
Driving a car?	<input type="checkbox"/> Yes	<input type="checkbox"/> Painful _____ minutes	<input type="checkbox"/> Not at all

Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Funny feelings - 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 \_\_\_\_\_

**Pain on touching the skin - 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 \_\_\_\_\_

**Shooting pains - 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 \_\_\_\_\_

**Colour changes - 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 \_\_\_\_\_

**Temperature changes - 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 \_\_\_\_\_

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

No       Yes \_\_\_\_\_

**Swelling - Does your affected area swell up?**

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 \_\_\_\_\_

**Do you suffer from cramping?** (If so, how often and how bothersome are the cramps?)

No       Yes \_\_\_\_\_

**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 list all pain medications you have taken in the past, why have you stopped them ?**

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

**Please look at all of the non-medication pain treatments below and if you have undergone such treatments, please comment how they affected your pain and your suffering**

Pain Treatments	When, by whom (if appropriate)	Helpful	Not helpful
Physiotherapy			
Heat Treatment			
TENS			
Acupuncture			
Epidural Steroid Injection			
Nerve Root Blocks			
Other Steroid Injections			
Chiropractic			
Hospital Bed rest			
Traction			
Psychology input, counselling			
Hypnosis			
Biofeedback			

**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

**Has your mood and temper changed since your pain started ?If so, how? What do other people say about your mood now?**

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

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**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 ? \_\_\_\_\_

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**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 → If yes, what was the response ?
- It has reduced the pain without making me feel drugged
- It didn't change the pain but made me feel more relaxed
- Nothing happened       The pain got worse

If you still use cannabis – how often? \_\_\_\_\_ / day/week (please circle)

**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>
<b>Little interest or pleasure in doing things</b>				
<b>Feeling down, depressed or hopeless</b>				
<b>Trouble falling or staying asleep, or sleeping too much</b>				
<b>Feeling tired or having little energy</b>				
<b>Poor appetite or overeating</b>				
<b>Feeling bad about yourself – or that you are a failure or have let yourself or your family down.</b>				
<b>Trouble concentrating on things, such as reading a newspaper or watching television</b>				
<b>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</b>				
<b>Thoughts that you would be better off dead, or of hurting yourself in some way</b>				

**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

**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? \_\_\_\_\_

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

**Aside from your pain problem, how is your general health (please check one) ?**

- Excellent       Minor Health Problems only       Major Health Problems

**Have you got any of the following health problems (please check all that apply)?**

- |   |  |
|---|--|
| <input type="checkbox"/> High Blood Pressure                  | <input type="checkbox"/> Diabetes                                      |
| <input type="checkbox"/> Angina or chest pain                 | <input type="checkbox"/> I have difficulties managing my diabetes      |
| <input type="checkbox"/> Heart attack                         | <input type="checkbox"/> Thyroid problems                              |
| <input type="checkbox"/> Kidney Problem                       | <input type="checkbox"/> Liver disease                                 |
| <input type="checkbox"/> Bowel problem                        | <input type="checkbox"/> Blood or clotting problem                     |
| <input type="checkbox"/> TIA or Stroke                        | <input type="checkbox"/> Seizure or epilepsy                           |
| <input type="checkbox"/> Chronic cough                        | <input type="checkbox"/> Cancer  |
| <input type="checkbox"/> Bleeding problem                     | <input type="checkbox"/> Stomach problem                               |
| <input type="checkbox"/> Arthritis                            | <input type="checkbox"/> Need for antibiotics prior to procedures      |
| <input type="checkbox"/> Lung problem / Tuberculosis/Asthma   | <input type="checkbox"/> Recent change in ability to care for yourself |
| <input type="checkbox"/> Recent fall within the last 3 months | <input type="checkbox"/> Other _____                                   |
| <input type="checkbox"/> _____                                |  |
| <input type="checkbox"/> _____                                |  |

**Have you undergone any operations linked to the pain problems you have ?**

Date	Type of operation, Name of Surgeon & Hospital

**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**

- How often do you have mood swings? \_\_\_\_\_
- How often have you felt a need for higher doses of medication to treat your pain? \_\_\_\_\_
- How often have you felt impatient with your doctor ? \_\_\_\_\_
- How often have you felt that things are just too overwhelming that you can't handle them ? \_\_\_\_\_
- How often is there tension in the home \_\_\_\_\_
- How often have you counted pain pills to see how many are remaining? \_\_\_\_\_
- How often have you been concerned that people will judge you for taking pain medication? \_\_\_\_\_
- How often do you feel bored? \_\_\_\_\_
- How often have you taken more pain medication than you were supposed to? \_\_\_\_\_
- How often have you worried about being left alone? \_\_\_\_\_
- How often have you felt a craving for medication? \_\_\_\_\_
- How often have others expressed concern over your use of medication? \_\_\_\_\_
- How often have any of your close friends had a problem with alcohol or drugs? \_\_\_\_\_
- How often have you felt consumed by the need to get pain medication? \_\_\_\_\_
- How often have others told you that you had a bad temper? \_\_\_\_\_
- How often have you run out of pain medication early? \_\_\_\_\_
- How often have others kept you from getting what you deserve? \_\_\_\_\_
- How often, in your lifetime, have you had legal problems or been arrested? \_\_\_\_\_
- How often have you attended an AA or NA meeting? \_\_\_\_\_
- How often have you been in an argument that was so out of control that someone got hurt? \_\_\_\_\_
- How often have you been sexually abused? \_\_\_\_\_
- How often have others suggested that you have a drug or alcohol problem? \_\_\_\_\_
- How often have you had to borrow pain medications from your family or friends? \_\_\_\_\_
- How often have you been treated for an alcohol or drug problem? \_\_\_\_\_

\_\_\_\_\_

**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 you have included the claim number which links your current pain to a valid injury. You will be seen under a contract with ACC where you do not need to obtain prior approval from your case manager!
3. Please make an appointment with me  
by calling 07 – 3459915 or  
via email [stephan.neff@painspecialists.co.nz](mailto:stephan.neff@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 !**