Please complete and fax, email or mail to:

ATTN: Dr. M. Gofeld

Pain Management Centre

Women’s College Hospital

76 Greenville Street, 5th Floor, Toronto, Ontario M5S 1B2

Email: Sandra.Tahal@wchospital.ca Fax: (416) 323-2666

Initial Assessment

Dear Patient

The purpose of the university hospital-based pain clinic is to diagnose your condition in order to make most appropriate recommendations and provide necessary treatment. To support these goals, we require that you complete this initial assessment form. This will help to determine whether our clinic is suitable to manage your problem and what your specific needs may be.

Although you may decide to skip certain questions, filling this questionnaire is mandatory.

Your appointment will not be scheduled if you failed to comply.

Thank you for your cooperation

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_**

Please describe why you are interested in pain management consultation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Please use the diagram below to shade in areas where you have pain. Please use pencil and brush all areas you feel pain. Put X at the area of your worst pain



**Pain Level and Interference**

Please rate your pain by circling the one number that describes your **AVERAGE** pain over the past week?

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

No Pain Most horrible pain

**Circle the one number that describes how much (during the past week) pain has interfered with your**

**1. General Activity**

 ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

I’m very active I’m bedridden

**2. Any specific activity that you would like to do. Name the activity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

I have no limitations Unable to do

**3. Enjoyment of Life**

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

I’m happy I’m in misery

**4. Family or household responsibilities**

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

I have no limitations Unable to do

**5. Ability to work or go to school**

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

I work/study full time I’m completely disable

**6. Sleep**

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

I sleep well I have no sleep at all

**TELL US ABOUT YOUR CONDITION:**

What do you think is causing your pain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you think your pain is a sign of some serious problem/disease that has yet to be diagnosed? ⃝Yes ⃝No

Do you think there is a cure for your pain? ⃝Yes ⃝No

What do you think is going to happen to your pain? ⃝Get better ⃝ Get worse ⃝Stay the same

Do you think you pain is affected by your stress levels and/or mood? ⃝Yes ⃝No

**MEDICATIONS**

Please list all medications you are CURRENTLY taking for PAIN, SLEEP and MOOD?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Medication | Strength (mg)  | Number of pillstaken per day | Does it help? | Do you have side effects?  |
| No | Somewhat | Yes |
|  |  |  |  |  |  |  |

In the PAST MONTH, how many times you took more pain medication than prescribed?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of prescribing physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MISCELLANEOUS:**

**Over the past two weeks, have you been bothered by these problems?**

Please tick the box that best describes you in each row

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Notat all | Severaldays | More daysthan not | Nearlyevery day |
| Feeling nervous, anxious, or on edge |  |  |  |  |
| Not being able to stop or control worrying |  |  |  |  |
| Feeling down, depressed, or hopeless |  |  |  |  |
| Little interest or pleasure in doing things  |  |  |  |  |

Are there unresolved legal/compensation issues related to your condition?

 ⃝Yes ⃝No If Yes: Name of Legal Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone or email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you work? ⃝Yes ⃝No If NO why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many alcoholic drinks (beer, wine, liquor) do you have in an AVERAGE WEEK? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke any tobacco products? ⃝Yes ⃝No If yes, how many per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke marijuana? ⃝Yes ⃝No If yes, how much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any other recreational drugs? ⃝Yes ⃝No

If yes, which drugs and how much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you...**

Please tick the box that best describes you on each row

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Have had nightmares about it or thought about it when you did not want to? |  |  |
| Tried hard not to think about it or went out of your way to avoid situationsthat reminded you of it? |  |  |
| Were constantly on guard, watchful, or easily startled? |  |  |
| Felt numb or detached from others, activities, or your surroundings? |  |  |