Persistent Pain Program Questionnaire

Please complete the following questionnaire to help us better understand your pain history. Our health care team will use this information to help guide your initial assessment. Working with you, we will help you create a plan of care based on your needs, goals, and resources. Remember that all information provided is **PRIVATE** and **CONFIDENTIAL**.

DEMOGRAPHICS	
Name (last):	Name (first):
Date of Birth (MMDDYYYY):	PHN:
Telephone:	Address:

TELL US ABOUT YOUR CURRENT PAIN
1. What year did your pain begin?
2. How did your pain begin?
3. What makes your pain feel better? (e.g. Activity, rest, medications, etc.)
4. What makes your pain feel worse? (e.g. Walking, sitting, bending, etc.)
5. When does your pain feel worse? (e.g. morning, noon etc.)

TELL US THE IMPACT PAIN HAS HAD ON YOUR LIFE
1. How has it impacted your MOOD?
2. How has it impacted your SOCIAL LIFE?
3. How has it impacted your RELATIONSHIPS?
4. How has it impacted your OCCUPATION?
5. How has it impacted your QUALITY OF LIFE?

Please RETURN the completed questionnaire to the: Grande Prairie Primary Care Network
104-11745 105 St. Grande Prairie, AB T8V8L1
Fax: 587-259-9774 Phone: 780-539-9204

Primary Care Network GRANDE PRAIRIE

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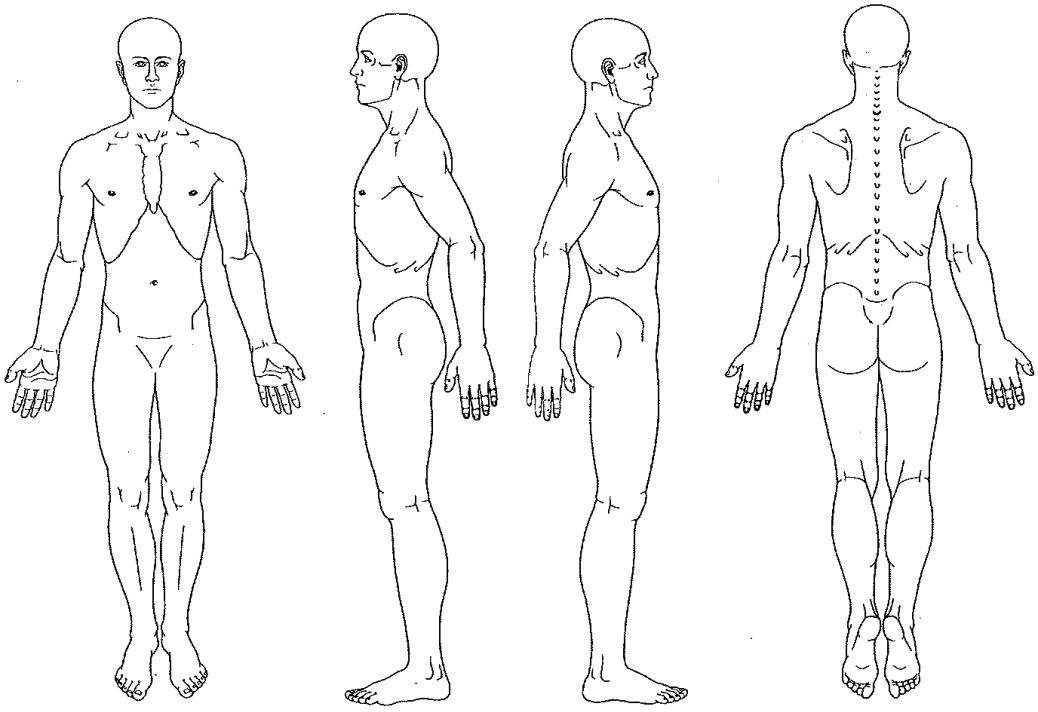
SHADE IN the area(s) where you FEEL pain. Put an X where your pain hurts THE MOST.
If your pain spreads, draw an ARROW from where it starts to where it stops.



THE CENTRALITY OF PAIN SCALE

Please rate how strongly you agree or disagree with each of these statements about your chronic pain on your current pain regimen. Think about how your pain has affected your life over the past month.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. Pain controls my life.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. I am able to live a full life despite my pain.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
3. My pain defines who I am.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. I have control over my pain most of the time.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
5. I think about pain all the time.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. My pain consumes all of my energy.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. My Life revolves around pain.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. Pain is a constant struggle for me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9. I can deal with my pain.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
10. Pain greatly interferes with my life.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

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TELL US WHO INVESTIGATED YOUR PAIN AND HOW			
Please include all X-rays, CT Scans, MRIs, bone scans, EMG or nerve conduction studies, EEGs, spinal tap or lumbar puncture, colonoscopy, functional capacity evaluation, nerve root injection, epidurals, etc. Indicate WHERE the test happened (clinic, hospital, etc.) and with WHO (doctor, specialist, radiologist, etc.).			
TEST	**WHEN?**	**WHERE?**	**WITH WHO?**

Are you currently waiting for any tests, scans, or procedures to investigate your pain? If yes, please explain:

TELL US ABOUT YOUR PRESCRIPTION MEDICATIONS
Please **BRING** with you an updated **LIST** of your current **PRESCRIPTION MEDICATIONS** or you may bring in **ALL** of your prescription medications to your initial appointment.

TELL US ABOUT ANY OTHER MEDICATIONS	
Please list any **NON-PRESCRIPTION** medications you currently take. These include vitamins, minerals, herbs, homeopathic products, topical creams, patches, puffers, supplements, and over the counter medications.	
1.	5.
2.	6.
3.	7.
4.	8.

TELL US ABOUT ALLERGIES	
Please list any MEDICATIONS that have given you an ALLERGIC REACTION and DESCRIBE the reaction	
Medication	**Allergic Reaction**
1.	
2.	
3.	

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TELL US ABOUT YOUR MEDICAL HISTORY				
Do you have a history of any of the following medical conditions? Please check all that apply.				
☐ Diabetes	☐ Heart Problems	☐ Kidney Problems	☐ Sleep Apnea	☐ Seizures
☐ COPD/Asthma	☐ Depression	☐ Anxiety	☐ Mental Health diagnosis	☐ High Blood Pressure
Please add any additional medical history, including surgeries:				
Please tell us about any family medical history of pain, substance abuse, or mental illness:				

TELL US ABOUT ANY SUBSTANCE USE				
Do you have a history of or are you currently using or consuming any of the following? Please check all that apply.				
Substance	**When did you start?**	**How much do you use/consume?**	**How often?**	**Have you ever quit?**
☐ Tobacco				
☐ Alcohol				
☐ Marijuana				
☐ Other:				

TELL US ABOUT YOURSELF

1. How ready are you to make a change to improve your function? Please circle a number

(Not Ready) 0 1 2 3 4 5 6 7 8 9 10 (Very Ready)

2. If you could make one change in your life right now to improve your function, what would it be?

THANK YOU FOR PLAYING AN ACTIVE ROLE IN YOUR HEALTH AND COMPLETING THIS QUESTIONNAIRE.

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