

PAIN QUESTIONNAIRE

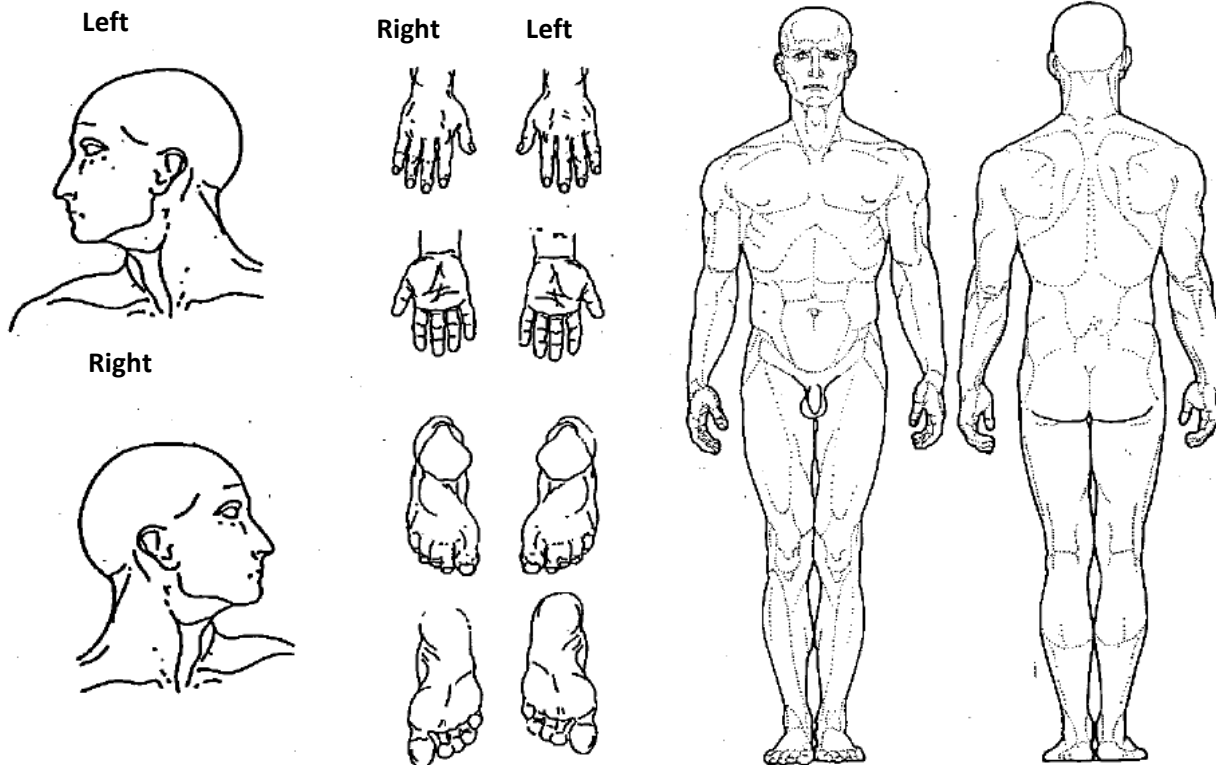
Name	Personal identity code
Home address	
Telephone	

1. Where does it hurt? In the picture, mark the areas of your body where you feel pain. Use the following markings to identify the type of pain.

Ache XXXXXX (draw crosses)

Tenderness ===== (draw horizontal lines)

Burning pain oooooo (draw circles) **Numbness** ||||| (draw vertical lines)



2. When did you experience the pain for the first time?

3. Is the pain

	Yes	No
continuous	<input type="checkbox"/>	<input type="checkbox"/>
varying in intensity	<input type="checkbox"/>	<input type="checkbox"/>
episodic	<input type="checkbox"/>	<input type="checkbox"/>

Do you experience pain

several times a week	<input type="checkbox"/>	<input type="checkbox"/>
several times a day	<input type="checkbox"/>	<input type="checkbox"/>

How long do the pain episodes last?
 seconds minutes hours days

4. Which factors worsen the pain? (For example, position, change in temperature)

5. What can you do to alleviate pain?

6. Which of the following can you do despite the pain?

	Well	To some extent	Not at all
Maintain relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memorize new things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enjoy a romantic relationship and sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enjoy hobbies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How is your general condition? Circle the number that best suits your current general condition.

Worst possible condition 0 1 2 3 4 5 6 7 8 9 10 Best possible condition

7. What is the main harm caused by the pain?

8. What is the intensity of your pain? Circle the number that best suits the intensity of your pain.

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

9. How stressed are you currently because of your pain? Circle the number that best suits your current stress level.

Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely stressed

10. If the pain cannot be completely removed, what would be the acceptable intensity of pain in your opinion? Circle the number that best suits the intensity of acceptable pain.

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

11. What do you think is the cause of your pain?

12a. Have you noticed changes in your mood? If yes, please specify what kind.

12b. Do you suspect the mood changes are associated with the pain?

13a. Which medicines have been used to treat your pain previously?

Medicine	Dose/day	Helped	Did not help	Caused side effects, please specify:
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

13b. Are you allergic to any medicines? No Yes, to _____

14. Has your pain been treated with any of the following? Please underline the ones that have been used.

	Helped	Did not help
Relaxation	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>
Mindfulness	<input type="checkbox"/>	<input type="checkbox"/>
Psychotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Physiotherapy	<input type="checkbox"/>	<input type="checkbox"/>
TENS (nerve stimulation)	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthesia	<input type="checkbox"/>	<input type="checkbox"/>
Other treatment, please specify _____	<input type="checkbox"/>	<input type="checkbox"/>

15. What are the important things to you that you would do, if your pain was under control? Please state 2 or 3 most important ones.

16. What are your aims for the treatment period at the Pain Clinic?

17a. Your education

- Comprehensive school
- Vocational school
- Upper secondary school (high school)
- Polytechnic
- University
- other, please specify: _____

17b. Your occupation

18. Are you employed

- full time
- part time

Are you

- on sick leave from ___ / ___ 20 ___ until ___ / ___ 20 ___
- on rehabilitation allowance from ___ / ___ 20 ___ until ___ / ___ 20 ___
- unemployed from ___ / ___ 20 ___
- retired from ___ / ___ 20 ___
- other reason for not working, please specify: _____

Do you currently have an unresolved social security matter? If yes, please specify:

Would you like to meet with a social worker? yes no

19. Who do you live with?

20. Intoxicants

- I do not smoke I smoke _____ cigarettes/day
- I do not drink alcohol I drink alcohol, type _____ amount _____ / week
- _____ / week
- _____ / week
- I do not use any other substances
- I use other substances, type _____ amount _____ / week
- _____ amount _____ / week

21. Exercise

Do you exercise regularly? yes no

Which sports? _____ times a week

22. Your height

Your weight

23. Who is your attending physician in primary care?

- Health center physician _____ clinic/unit: _____
- Occupational health physician _____
- Some other physician _____

24. Are you currently treated elsewhere, or are you waiting for examinations or treatment elsewhere? Please specify: