HOSPITAL DISTRICT OF HELSINKI AND UUSIMAA
HUS Pain Clinic

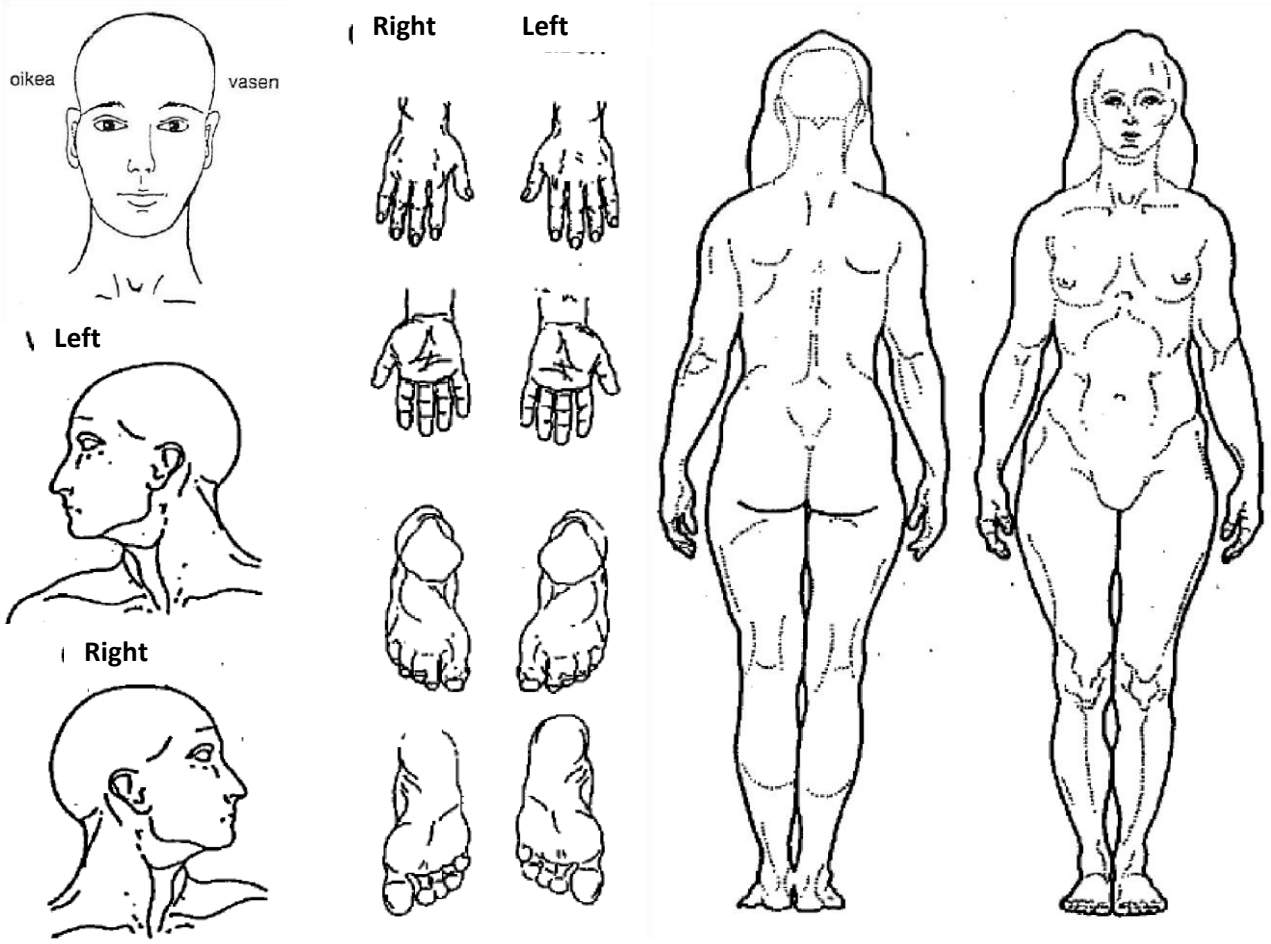
Date ____ / ____ 20___

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	□	□
varying in intensity	□	□
episodic	□	□

Do you experience pain

several times a week	□	□
several times a day	□	□

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 extend	Not at all
Maintain relationships	□	□	□
Concentrate	□	□	□
Memorize new things	□	□	□
Sleep	□	□	□
Enjoy a romantic relationship and sex	□	□	□
Perform chores	□	□	□
Enjoy hobbies	□	□	□
Travel	□	□	□
Other, please specify:_____	□	□	□

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:
_____		□	□	□ _____
_____		□	□	□ _____
_____		□	□	□ _____
_____		□	□	□ _____
_____		□	□	□ _____
_____		□	□	□ _____

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	□	□
Acupuncture	□	□
Mindfullness	□	□
Psychotherapy	□	□
Physiotherapy	□	□
TENS (nerve stimulation)	□	□
Local anesthesia	□	□
Other treatment, please specify _____	□	□

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 **17b. Your occupation**

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

18. Are you employed **Are you**

□ full time □ on sick leave from ___ /___ 20 ___ until ___ / ___ 20 ___
□ part time □ 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: