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PERSISTENT PAIN SERVICE (PPS) REFERRAL QUESTIONNAIRE

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(Tick ☑ as appropriate, format time as 00:00 (24 hour) and date as DD/MM/YYYY)

FT1554405

Section 1 – Your Details

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss	**Family surname** *(print):*	**Given name/s** *(print):*	
Gender: ☐ Male ☐ Female	**Date of birth:** DD / MM / YYYY	**Today's date:** DD / MM / YYYY	

Address: Number and Street:_ _____

City/Suburb:_____ Postcode: _____ State:_____

Phone: Home:_____ Work:_____ Mobile:_____

Email Address:_____

Country of Birth: ☐ Australia ☐ New Zealand ☐ Other *(specify)*: _____

Do you require an interpreter? ☐ Yes ☐ No

*If you answered yes, please specify the language:*_____

Are you hearing or sight impaired? ☐ Yes ☐ No

Do you require help with written or spoken communication? ☐ Yes ☐ No

Height: centimetres **Weight:** kilograms

Are you of Aboriginal or Torres Strait Islander origin? *(more than one may be ticked)*

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

Have you ever served in the Australian Defence Force? ☐ Yes ☐ No

Are you a client of the Department of Veterans' Affairs or have you received a benefit or support from the Department of Veterans' Affairs? ☐ Yes ☐ No

Is there a compensation case relating to this episode? ☐ Yes ☐ No

(If yes, record the type of compensation):

☐ Worker's Compensation ☐ Public Liability

☐ Motor Vehicle ☐ Other *(specify)*:_____

How did your main pain begin?

☐ Injury at home ☐ Motor vehicle crash ☐ After surgery

☐ Injury at work/school ☐ Cancer ☐ No obvious cause

☐ Injury in another setting ☐ Medical condition other than cancer ☐ Other *(specify)*:

_____

How long has your main pain been present? *(Tick one box only)*

☐ Less than 3 months ☐ 12 months to 2 years ☐ More than 5 years

☐ 3 to 12 months ☐ 2 to 5 years

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Which statement best describes your pain? *(Tick one box only)*

- ☐ Always present (always the same intensity)
- ☐ Always present (level of pain varies)
- ☐ Often present (pain free periods last less than 6 hours)
- ☐ Occasionally present (pain occurs once to several times per day, lasting up to an hour)
- ☐ Rarely present (pain occurs every few days or weeks)

Do you have any of the following?

- ☐ A mental health condition, in particular: ☐ PTSD ☐ Anxiety ☐ Depression

  Other *(specify)*: _____
- ☐ Arthritis *(including Rheumatoid/Osteoarthritis)*
- ☐ Muscle, bone and joint problems **other than arthritis** *(including Osteoporosis, Fibromyalgia)*
- ☐ Heart and circulation problems *(including Heart Disease, Pacemaker, Blood Disease)*

  In particular specify if you have: ☐ High Blood Pressure ☐ High Cholesterol
- ☐ Diabetes
- ☐ Digestive problems *(including Irritable Bowel Syndrome (IBS), GORD, Stomach Ulcers, Reflux, Bowel Disease)*
- ☐ Respiratory problems *(including Asthma, Lung Disease, Chronic Obstructive Pulmonary Disorder (COPD), Sleep Apnoea)*
- ☐ Neurological problems *(including Stroke, Epilepsy, Multiple Sclerosis, Parkinson's Disease)*
- ☐ Cancer
- ☐ Liver, kidney and pancreas problems *(including Pancreatitis, Kidney Disease)*
- ☐ Thyroid problems *(including Hyperactive or Hypoactive Thyroid, Graves' Disease)*
- ☐ Any other medical conditions *(specify)*: _____

_____

Health care *(other than your visits to the pain clinic)*

1. How many times in the past 3 months have you seen a general practitioner in regard to your pain? _____ times
2. How many times in the past 3 months have you seen a medical specialist *(for example orthopaedic surgeon)* in regard to your pain? _____ times
3. How many times in the past 3 months have you seen health professionals other than doctors *(for example physiotherapist, chiropractor, psychologist)* in regard to your pain? _____ times
4. How many times in the past 3 months have you visited a hospital emergency department in regard to your pain? *(Include all visits, regardless of whether or not you were admitted to the hospital from the emergency department)* _____ times
5. How many times in the past 3 months have you been admitted to hospital as an inpatient because of your pain? _____ times
6. How many diagnostic tests (for example x-rays, scans) have you had in the last 3 months relating to your pain? _____ tests

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Section 2 – Your Work

Are you currently employed (working for pay)?

☐ Yes - If *yes*, are you:

☐ Working full-time

☐ Working part-time

*(tick **one** only, then go straight to **Section 3**)*

Please answer the questions below:

☐ No - If *no*, are you:

☐ Unable to work due to a condition other than pain

☐ Unable to work due to pain

☐ Not working by choice *(student, retired, homemaker)*

☐ Seeking employment *(I consider myself able to work but cannot find a job)*

During the past seven days, how many hours did you miss from work because of problems *associated with your pain?* *(Include hours you missed on sick days, times you went in late, left early because of your pain. Do not include time you missed to attend this pain clinic).* _____ hours

During the past seven days, how many hours did you actually work?

*(If '0' skip the next question and go to **Section 3**)* _____ hours

During the past seven days, how much did your pain affect your productivity *while you were working?*

Think about days you were limited in the amount or kind of work you could do, days you accomplished less than you would like, or days you could not do your work as carefully as usual.

If pain affected your work only a little, choose a low number.

Choose a high number if pain affected your work a great deal.

Consider only how much **pain** affected productivity **while you were working**

0	1	2	3	4	5	6	7	8	9	10
Pain had no effect on my work										Pain completely prevented me from working

CIRCLE A NUMBER

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Section 3 – Medication Use

Are you taking any medications?

☐ No *(please go to **Section 4**)*

☐ Yes *(please list **all** the medications you are taking. Include both prescription **and** over-the-counter medicines)*

Medicine name *(as on the label)*	Medicine strength *(as on the label)*	How many do you take per day?	How many days per week do you take this medication?

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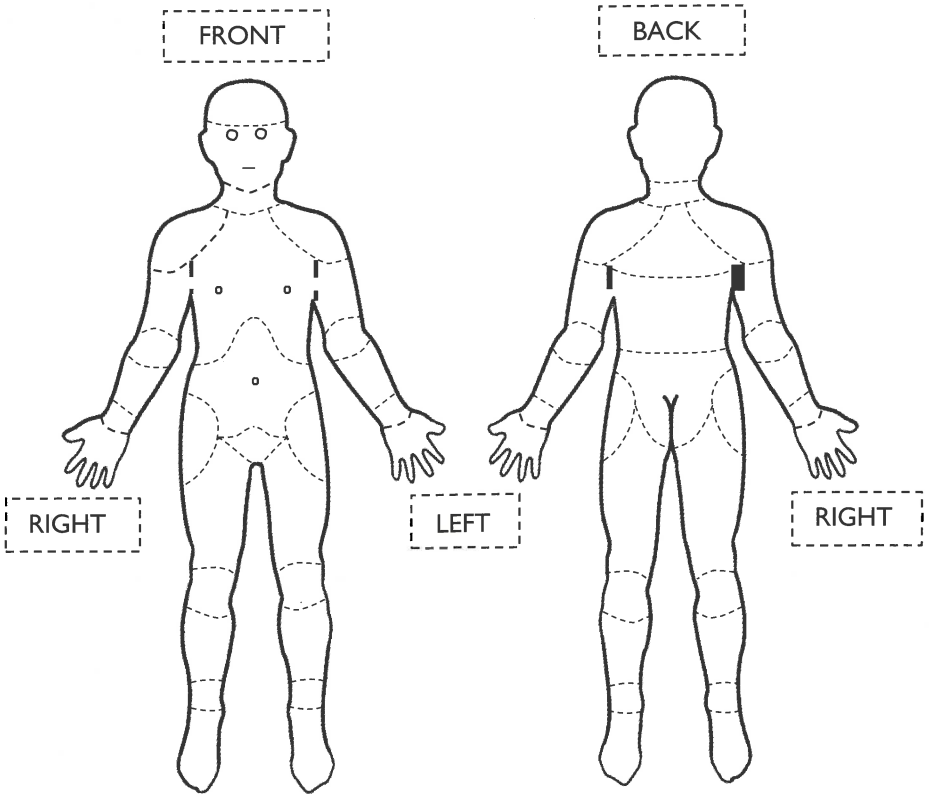
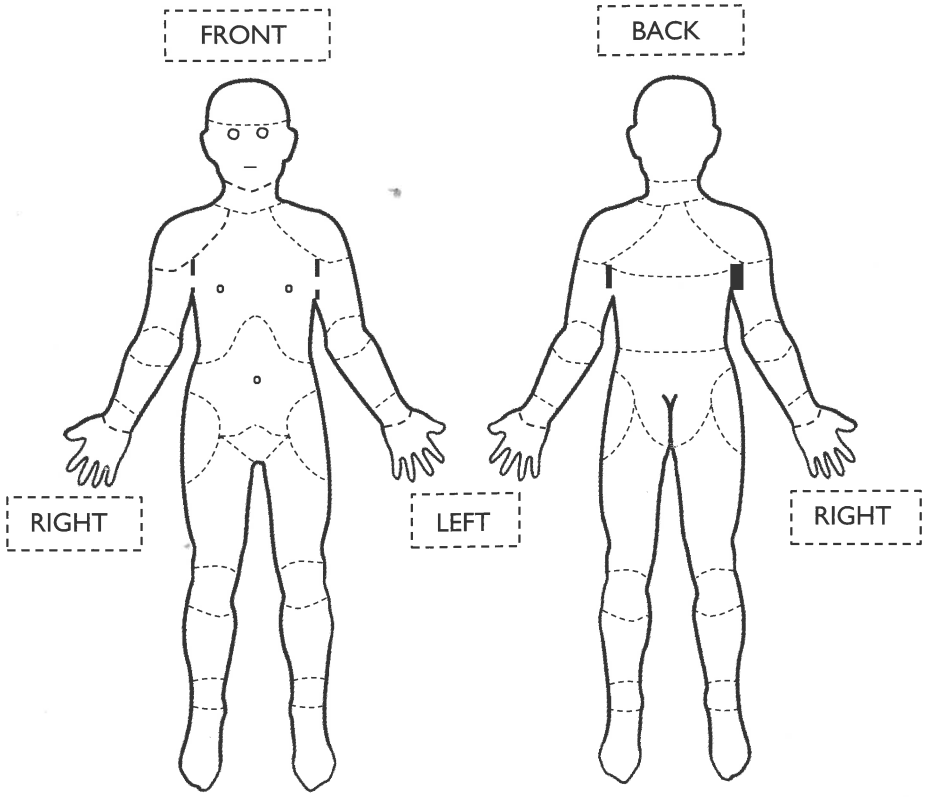
Section 4 – Pain Intensity and Interference

On the diagram below, shade in ALL the areas where you feel pain.



On the diagram below, put an X on the ONE area that hurts most.



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Please rate your pain by circling the one number that best describes the following:											
1. Your pain at its worst in the last week?	0	1	2	3	4	5	6	7	8	9	10
	No pain										Pain as bad as you can imagine
2. Your pain at its least in the last week?	0	1	2	3	4	5	6	7	8	9	10
	No pain										Pain as bad as you can imagine
3. Your pain on average?	0	1	2	3	4	5	6	7	8	9	10
	No pain										Pain as bad as you can imagine
4. How much pain do you have right now?	0	1	2	3	4	5	6	7	8	9	10
	No pain										Pain as bad as you can imagine
During the past week, how much has pain interfered with the following:											
1. Your general activity?	0	1	2	3	4	5	6	7	8	9	10
	Does not interfere										Completely interferes
2. Your mood?	0	1	2	3	4	5	6	7	8	9	10
	Does not interfere										Completely interferes
3. Your walking ability?	0	1	2	3	4	5	6	7	8	9	10
	Does not interfere										Completely interferes
4. Your normal work (both outside the home and housework)?	0	1	2	3	4	5	6	7	8	9	10
	Does not interfere										Completely interferes
5. Your relations with other people?	0	1	2	3	4	5	6	7	8	9	10
	Does not interfere										Completely interferes
6. Your sleep?	0	1	2	3	4	5	6	7	8	9	10
	Does not interfere										Completely interferes
7. Your enjoyment of life?	0	1	2	3	4	5	6	7	8	9	10
	Does not interfere										Completely interferes

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Section 5 – DASS21

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all

1 Applied to me to some degree, or some of the time

2 Applied to me to a considerable degree, or a good part of the time

3 Applied to me very much, or most of the time

	Not at all	Some of the time	A good part of the time	Most of the time
1. I found it hard to wind down	0	1	2	3
2. I was aware of dryness of my mouth	0	1	2	3
3. I couldn't seem to experience any positive feeling at all	0	1	2	3
4. I experienced breathing difficulty *(for example excessively rapid breathing, breathlessness in the absence of physical exertion)*	0	1	2	3
5. I found it difficult to work up the initiative to do things	0	1	2	3
6. I tended to overreact to situations	0	1	2	3
7. I experienced trembling *(for example in the hands)*	0	1	2	3
8. I felt that I was using a lot of nervous energy	0	1	2	3
9. I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10. I felt that I had nothing to look forward to	0	1	2	3
11. I found myself getting agitated	0	1	2	3
12. I found it difficult to relax	0	1	2	3
13. I felt down-hearted and blue	0	1	2	3
14. I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15. I felt I was close to panic	0	1	2	3
16. I was unable to become enthusiastic about anything	0	1	2	3
17. I felt I wasn't worth much as a person	0	1	2	3
18. I felt that I was rather touchy	0	1	2	3
19. I was aware of the action of my heart in the absence of physical exertion *(for example a sense of heart rate increase, heart missing a beat)*	0	1	2	3
20. I felt scared without any good reason	0	1	2	3
21. I felt that life was meaningless	0	1	2	3

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Section 6 – PSEQ

Rate how confident you are that you can do the following things **at present** despite the pain. Circle one of the numbers on the scale under each item, where 0 = *Not at all confident* and 6 = *Completely confident.*

Remember this questionnaire is not asking whether or not you have been doing these things, but rather how confident you are that you can do them at present, **despite the pain**.

1.	I can enjoy things, despite the pain	0 Not at all confident	1	2	3	4	5	6 Completely confident
2.	I can do most of the household chores *(for example tidying up, washing dishes.)* despite the pain	0 Not at all confident	1	2	3	4	5	6 Completely confident
3.	I can socialise with my friends or family members as often as I used to do, despite the pain	0 Not at all confident	1	2	3	4	5	6 Completely confident
4.	I can cope with my pain in most situations	0 Not at all confident	1	2	3	4	5	6 Completely confident
5.	I can do some form of work, despite the pain *("work" includes housework, paid and unpaid work)*	0 Not at all confident	1	2	3	4	5	6 Completely confident
6.	I can still do many of the things I enjoy doing, such as hobbies or leisure activity, despite the pain	0 Not at all confident	1	2	3	4	5	6 Completely confident
7.	I can cope with my pain without medication	0 Not at all confident	1	2	3	4	5	6 Completely confident
8.	I can still accomplish most of my goals in life, despite the pain	0 Not at all confident	1	2	3	4	5	6 Completely confident
9.	I can live a normal lifestyle, despite the pain	0 Not at all confident	1	2	3	4	5	6 Completely confident
10.	I can gradually become more active, despite the pain	0 Not at all confident	1	2	3	4	5	6 Completely confident

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Section 7 – PCS

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
1. I worry all the time about whether the pain will end	0	1	2	3	4
2. I feel I can't go on	0	1	2	3	4
3. It's terrible and I think it's never going to get any better	0	1	2	3	4
4. It's awful and I feel it overwhelms me	0	1	2	3	4
5. I feel I can't stand it anymore	0	1	2	3	4
6. I become afraid that the pain will get worse	0	1	2	3	4
7. I keep thinking of other painful events	0	1	2	3	4
8. I anxiously want the pain to go away	0	1	2	3	4
9. I can't seem to keep it out of my mind	0	1	2	3	4
10. I keep thinking about how much it hurts	0	1	2	3	4
11. I keep thinking about how badly I want the pain to stop	0	1	2	3	4
12. There's nothing I can do to reduce the intensity of the pain	0	1	2	3	4
13. I wonder whether something serious may happen	0	1	2	3	4

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Medication

Did the patient report medications? ☐ Yes ☐ No

Possible differences in patient-reported medications? ☐ Yes ☐ No

Tick all drug groups being taken:

☐ Opioids ☐ Paracetamol ☐ NSAIDs ☐ Medical Cannabinoids

☐ Antidepressants ☐ Anticonvulsants ☐ Benzodiazepines

Daily oral morphine equivalent: _____ milligrams (mg)

Opioid medication greater than 2 days/week ☐ Yes ☐ No

Opioid replacement/substitution program? ☐ Yes ☐ No

Print name:	Designation:
Signature:	Date: DD / MM / YYYY

Questionnaire sent: DD / MM / YYYY
Questionnaire received: DD / MM / YYYY

Acknowledgements

We acknowledge use of the following questions and assessment tools:

- Pain Chart: Childhood Arthritis and Rheumatology Research Alliance, www.carragroup.org von Baeyer CL et al, Pain Management, 2011;1(1):61-68
- Modified Brief Pain Inventory questions, reproduced with acknowledgement of the Pain Research Group, the University of Texas MD Anderson Cancer Centre
- Depression, Anxiety and Stress Scale, Lovibond SH & Lovibond PF (1995)
- Pain Self-Efficacy Questionnaire, Nicholas MK (1989)
- Pain Catastrophising Scale, Sullivan MJL (1995)
- Work productivity questions from the Work Productivity and Activity Impairment Questionnaire, Reilly MC, Zbrozek AS & Dukes EM (1993)
- University of Wollongong

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Additional Questions

Have you been to a pain clinic before? *(give details)* _____

Are you currently visiting another pain clinic? *(give details)* _____

How does your main pain feel to you? *(for example tingling, burning, throbbing, aching, radiating, numbness, stabbing)*

In the last week, how much relief have you had from pain treatments or medications?

0% 10 20 30 40 50 60 70 80 90 100%

No relief at all — Complete relief No Pain

Do you think you need more or stronger medication for pain?

0 1 2 3 4 5 6

Disagree Strongly — Unsure — Agree Strongly

What other medications have you tried for your pain? _____

What other medications are you taking for reasons **other than** pain now: _____

Please list any operations you have had **related to your pain**:

Type of Operation	Year	Surgeon	Was it helpful for pain? Yes/No

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Please tick other treatments that you have tried for pain and whether they were helpful:

Treatment	Never Tried	Helpful	No help	Pain worse	Ongoing
Nerve blocks					
Transcutaneous electrical nerve stimulation (TENS)					
Bed rest in hospital					
Bed rest with traction					
Psychology					
Hypnosis					
Relaxation					
Acupuncture					
Chiropractic					
Osteopathic					
Physiotherapy (hands on)					
Hydrotherapy					

Do you smoke cigarettes? ☐ Yes ☐ No

How many days of the week do you take alcohol?

☐ Non-drinker ☐ Less than 1 day per week ☐ 1 day per week

☐ 2-5 days per week ☐ More than 5 days per week

If you take alcohol, how many standard drinks do you usually take at a time?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 6-7 ☐ 7-8 ☐ 8-15 ☐ More than 15

Do you take alcohol to relieve pain? ☐ Yes ☐ No

Do you use other substances? ☐ Yes ☐ No

What was your main occupation before your pain/injury?

What do you think your **future** employment / work situation will be 1 year from now?

☐ Full time work ☐ Part time work ☐ Seeking employment

☐ Unable to work due to pain ☐ Unable to work due to a condition other than pain

☐ Not working by choice (student, retired, homemaker)

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RMDQ

When pain hurts, you may find it difficult to do some things you normally do. This list contains sentences people have used to describe themselves when they have pain. You may find that some stand out more than others because they describe you today. When you read a sentence that describes you today, put a tick against it. If the sentence does not describe you, then leave the box blank and go on to the next one. Remember; only tick the sentences if you are sure that it describes you today.

1. I stay at home most of the time because of my pain _____ ☐
2. I change position frequently to try to get my pain comfortable _____ ☐
3. I walk more slowly than usual because of my pain _____ ☐
4. Because of my pain, I am not doing any of the jobs that I usually do around the house _____ ☐
5. Because of my pain, I use a handrail to get up stairs _____ ☐
6. Because of my pain, I lie down to rest more often _____ ☐
7. Because of my pain, I have to hold on to something to get out of an easy chair _____ ☐
8. Because of my pain, I try to get other people to do things for me _____ ☐
9. I get dressed more slowly than usual because of my pain _____ ☐
10. I only stand up for short periods of time because of my pain _____ ☐
11. Because of my pain, I try not to bend or kneel down _____ ☐
12. I find it difficult to get out of a chair because of my pain _____ ☐
13. I am in pain almost all of the time _____ ☐
14. I find it difficult to turn over in bed because of my pain _____ ☐
15. My appetite is not good because of my pain _____ ☐
16. I have trouble putting on my socks (or stockings) because of my pain _____ ☐
17. I only walk short distances because of my pain _____ ☐
18. I sleep less well because of my pain _____ ☐
19. Because of my pain, I get dressed with help from someone else _____ ☐
20. I sit down for most of the day because of my pain _____ ☐
21. I avoid heavy jobs around the house because of my pain _____ ☐
22. Because of my pain, I am more irritable and bad tempered with people than usual _____ ☐
23. Because of my pain, I go up stairs more slowly than usual _____ ☐
24. I stay in bed most of the time because of my pain. _____ ☐

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Are there particular questions you would like answered by coming to our service?

What will you be hoping to achieve from coming to see us?

Your Story - If you want to, this section is for you to tell us ***your*** story. This may be the story of your pain and how it affects you and your lifestyle, or what you do now to manage the effect of pain on your life. *(Feel free to use blank page opposite)*

Who helped you to fill in this questionnaire?

☐ No help needed ☐ Family member ☐ Friend ☐ Health professional

☐ Other *(specify)*: _____

Thank you for completing the Referral Questionnaire.
If you would like further information about persistent pain, you may like to visit:
www.hnehealth.nsw.gov.au/pain

Abbreviation key: **DASS** Depression, Anxiety and Stress Scale | **GORD** Gastroesophageal Reflux Disease | **NSAIDs** Non-Steroidal Anti-Inflammatory Drugs | **PSEQ** Pain Self Efficacy Questionnaire | **PTSD** Post Traumatic Stress Disorder | **RMDQ** Roland Morris Disability Questionnaire