Date of filling out Questionnaire _____

Last Name _____ **First Names** _____

How do you like to be called _____

Street Address _____

Town _____ **Post Code** _____

Phone (___) _____ **Mobile** _____

Date of Birth _____ ☐ Female ☐ Male **NHI Number** _____

Age _____ **Height** _____ **(cm)** **Weight** _____ **(kg)**

Email address _____

Are you happy for us to email you your letters? ☐ Yes ☐ No

Please list the names and mailing addresses of all Health Care Professionals involved in your care (incl. GPO, Specialists, Physiotherapists, Chiropractors, etc.):

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

Funding of Pain consult

☐ Private Insurance: _____ Approval number _____

☐ ACC: Date of Accident _____Claim number _____

Case Manager _____ ACC Branch _____

☐ Other _____

Marital Status (at present)

☐ Single / Never married ☐ Married; how long _____

☐ Widowed ☐ Separated / Divorced

Number of children _____ **Age of Children** _____

With whom are you currently living ?

☐ Alone ☐ Parent ☐ Spouse ☐ Others

How many children live with you ? _____

Current Occupation (specify titles)

_____

Current Employer _____

_____

How many hours do you work per week _____

If you are not working, please tell us your previous occupation

_____

Occupation of Spouse _____

Ethnic Group (we are obliged to collect this data)

☐ NZ Maori ☐ NZ European ☐ Chinese ☐ Indian ☐ Asian

☐ European Which country ?_____

☐ Other _____

What **language** do you usually speak ?

☐ English ☐ Maori ☐ Other _____

If non-English speaking or deaf, do you need an **interpreter** ? ☐ Yes ☐ No

Do you require a **support person** to attend your appointments ? ☐ Yes ☐ No

Please comment _____

Do you require **assistance with transport** to attend your appointments ? ☐ Yes ☐ No

Please comment _____

Please let us know **which of the following locations** is preferable to you to see Dr. Neff

☐ Southern Cross Hospital, Rotorua

☐ 7 Thackeray Street, Hamilton (Anglesea Sports & Physiotherapy Clinic)

☐ 27-28 Douglas McLean Ave, Marewa, Napier 4110 (Central Medical)

Please tell me more about your pain !

What is the main problem for which you are seeking help?

_____

How many other pain problems have you got ? ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ > 4

Pain 1 _____

Pain 2 _____

Pain 3 _____

Pain 4 _____

Pain 5 _____

Pain 6 _____

Which pain bothers you most ? _____

When and how did your most important pain start ? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Has the type of pain changed over time ? ☐ No ☐ Yes, How _____

_____

_____

Has the severity changed? ☐ Better over time ☐ Unchanged ☐ Worse

When and how did any other pains start ? _____

_____

_____

_____

_____

_____

_____

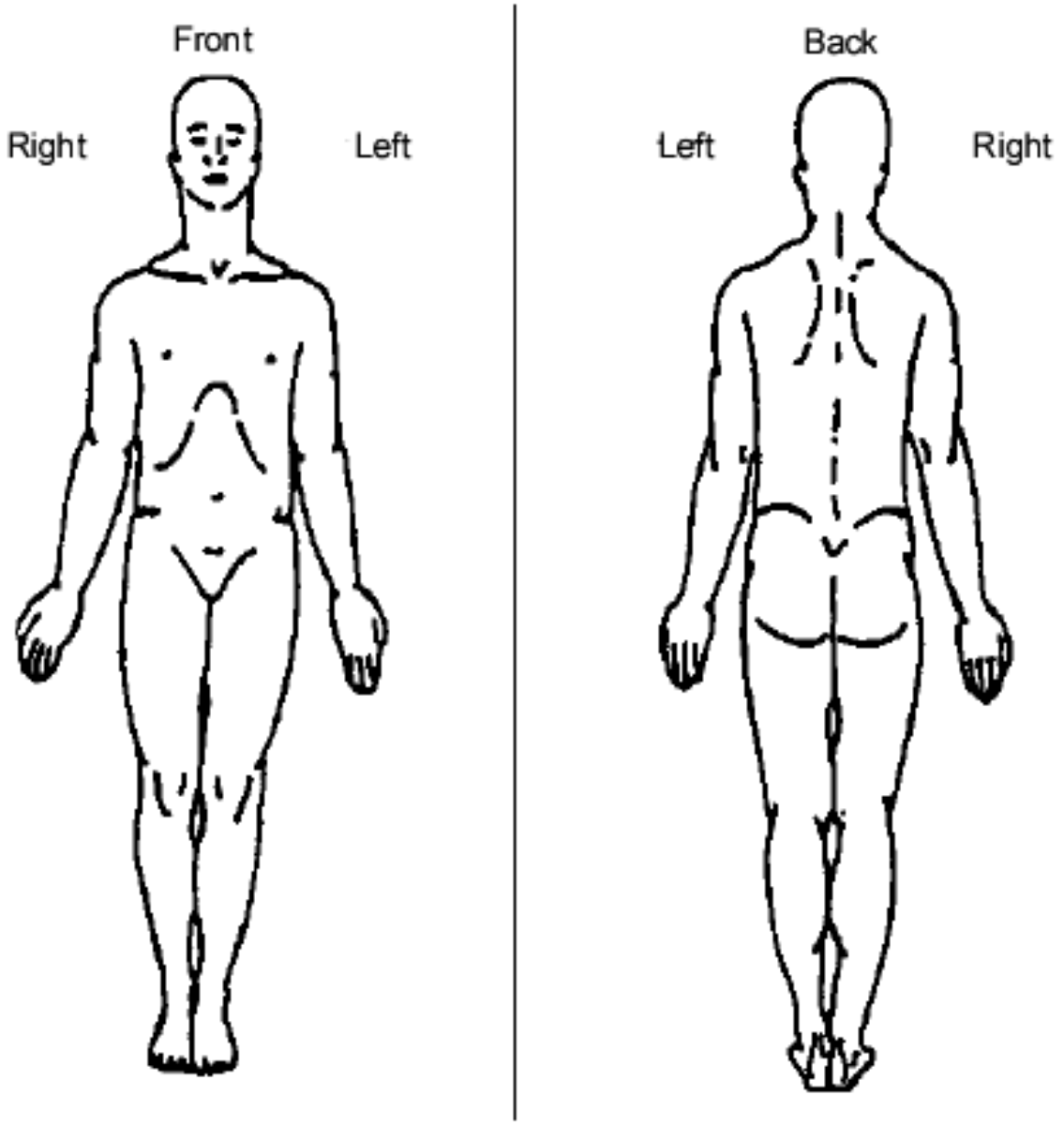
_____

_____

On the diagram, shade in the areas where you feel pain

Put an X on the area that hurts most

Add the letter "I" for Internal Pain (deep inside)
"E" for External Pain (skin level)
"IE" for pain that feels deep inside and at the skin level



How often do you have your pain (please check one)

- ☐ Constantly (100 % of the time)
- ☐ Nearly constantly (60-95 % of the time)
- ☐ Intermittently (30-60 % of the time)
- ☐ Occasionally (less than 30 % of the time)

In general, during the past month **when has your pain been the worst** (please check one)?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ No typical pattern

For each pain you are suffering please indicate the following
(Please use different colours or mark differently for each pain)

Please rate your pain by circling the one number that best describes your pain at its **worst** in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10

(No pain) (Pain as bad as you can imagine)

Please rate your pain by circling the one number that best describes your pain at its **least** in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain by circling the one number that best describes your pain **on average**.

0 1 2 3 4 5 6 7 8 9 10

Please tell me how closely each of these words describe your pain. Please mark each word below ! If you suffer from multiple pains – use different colour to describe each pain in itself !

	None	Mild	Moderate	Severe
Throbbing	_____	_____	_____	_____
Shooting	_____	_____	_____	_____
Stabbing	_____	_____	_____	_____
Sharp	_____	_____	_____	_____
Cramping	_____	_____	_____	_____
Gnawing	_____	_____	_____	_____
Hot-burning	_____	_____	_____	_____
Aching	_____	_____	_____	_____
Heavy	_____	_____	_____	_____
Tender	_____	_____	_____	_____
Splitting	_____	_____	_____	_____
Tiring-exhausting	_____	_____	_____	_____
Sickening	_____	_____	_____	_____
Fearful	_____	_____	_____	_____
Punishing-cruel	_____	_____	_____	_____

How would you describe your pain to a friend (not a medical person)? _____

_____

_____

_____

_____

How do the following affect your pain (please check one for each item)? (Use different colours if you are suffering from multiple pains)

	Makes it better	No effect	Makes it worse
Lying down	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Exercise	☐	☐	☐
Relaxation	☐	☐	☐
Thinking about something else	☐	☐	☐
Coughing/ Sneezing	☐	☐	☐
Passing water	☐	☐	☐
Bowel movements	☐	☐	☐
Heat (e.g. a wheat bag)	☐	☐	☐
Cold	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

Funny feelings - Does your pain feel like strange, unpleasant sensations in your skin ? Words like pricking, tingling, pins and needles might describe these sensations (please tell us more about those sensations including where you can feel those sensations)

☐ No ☐ Yes _____

Pain on touching the skin - Does your pain make the affected skin abnormally sensitive to touch ? Getting unpleasant sensations when lightly stroking the skin or getting pain when wearing tight clothes might describe the abnormal sensitivity. (please describe)

☐ No ☐ Yes _____

Shooting pains - Does your pain come on suddenly and in bursts for no apparent reasons when you're still? Words like electric shocks, jumping and bursting describe these features. (please describe)

☐ No ☐ Yes _____

Colour changes - Does your pain make the skin in the painful area look different from normal ? Words like mottled or looking more red or pink might describe the appearance. (please describe)

☐ No ☐ Yes _____

Temperature changes - Does your pain feel as if the skin temperature in the painful area has changed abnormally ? Words like hot, burning and freezing might describe these sensations. (please describe)

☐ No ☐ Yes _____

Sweating changes - Does your affected area sweat differently? Either more or less compared with the other side

☐ No ☐ Yes _____

Swelling - Does your affected area swell up?

☐ No ☐ Yes _____

Do muscles in the affected area at times move without your control? (Flickering of muscles under the skin, tendency to drop things, leg giving way, etc.)

☐ No ☐ Yes _____

Do you suffer from cramping? (If so, how often and how bothersome are the cramps?)

☐ No ☐ Yes _____

How does the pain interfere with your life ?

During the past month, how much did pain interfere with the following activities

	Not at all	Extremely
Going to work	_____	
Household chores	_____	
Going shopping	_____	
Socialising with friends	_____	
Participating in recreation	_____	
Having sexual relations	_____	
Physically exercising	_____	
Eating	_____	

How long can you sit? _____ minutes

How long can you stand? _____ minutes

How far can you walk? _____ metres

Can you bend or twist your back ? ☐ Yes ☐ Yes but painful ☐ No

Can you squat? ☐ Yes ☐ Yes but painful ☐ No

Repetitive movements with your arms

Can you write? ☐ Yes ☐ Painful _____ minutes ☐ Not at all

Keyboarding? ☐ Yes ☐ Painful _____ minutes ☐ Not at all

Using hand tools? ☐ Yes ☐ Painful _____ minutes ☐ Not at all

Driving a car? ☐ Yes ☐ Painful _____ minutes ☐ Not at all

Comments _____

_____

_____

_____

Have you got difficulties going to sleep ? ☐ No ☐ Yes _____

How many hours do you sleep on a typical night ? _____ **hrs**

How many times are you woken by pain on a typical night ? _____

Do you snore ? _____

Have you been told that you stop breathing during the night for some seconds ? _____

Do you ever fall asleep in places where you don't want to (GP surgery, etc) _____

How often during the day do you lie down because of the pain ? _____

How many hours would you spend lying down during the day ? _____hours

What do you do if the pain gets really bad ?

_____

_____

_____

_____

_____

_____

_____

Please tick any of the following coping mechanisms if you use it regularly for your pain

Meditation	☐	Pacing	☐	Goal-Setting	☐
Distraction	☐	Relaxation	☐	_____	☐

List 4 activities / goals you would like to achieve if your pain level is improved. How much does your pain interfere with these activities right now? (Please give us a number between 0 and 10, 0 meaning no interference, 10 meaning extreme interference)

Your Goal	Interference (0-10)
_____	_____
_____	_____
_____	_____
_____	_____

Many People experience pain, Fatigue (i.e. feeling tired), emotional distress (e.g. worries, feeling sad) and interference with daily activities (e.g. not being able to work or do household chores) as a result of their medical condition. We would like to understand how you have been impacted in each of these areas. We would also like to learn more about what you want your treatment to do for you.

Firstly, we would like to know your usual levels of pain, fatigue, emotional distress and interference.

On a scale of 0 (none) to 10 (worst imaginable), please indicate your usual level (during the past week) of ….

- Pain _____
- Fatigue _____
- Emotional distress _____
- Interference with daily activities _____

Now, we would like to learn about you desired levels of pain, fatigue, emotional distress and interference. In other words, we would like to understand what your ideal treatment outcome would be.

On a scale of **0 (none) to 10 (worst imaginable)**, please indicate your **desired level** of ….

- Pain _____
- Fatigue _____
- Emotional distress _____
- Interference with daily activities _____

Patients understandably want their treatment to result in desired or ideal treatment outcomes like you indicated above. Unfortunately, available treatments do not always produce desired outcomes. Therefore, it is important for us to understand what treatment outcomes you would consider successful.

On a scale of **0 (none) to 10 (worst imaginable)**, please indicate the level each of these areas would have to be at for you to consider treatment successful.

- Pain _____
- Fatigue _____
- Emotional distress _____
- Interference with daily activities _____

Any further comments with regards to your pain ?

_____

_____

_____

_____

_____

Please list all medications, especially pain killers, you are taking now for any reason, whether prescribed by a doctor or not (include home remedies, vitamins, herbs, birth control pills, etc.)

Name of Drug	Dosage	How many times a day	Reasons

Do you have any allergies ?

☐ Yes ☐ No If yes, please list _____

_____

Please list all pain medications you have taken in the past, why have you stopped them ?

Name of Drug	Maximum dose	How many times a day	Did it make the pain better	Side Effects

Please look at all of the non-medication pain treatments below and if you have undergone such treatments, please comment how they affected your pain and your suffering

Pain Treatments	**When, by whom** (if appropriate)	**Helpful**	**Not helpful**
Physiotherapy			
Heat Treatment			
TENS			
Acupuncture			
Epidural Steroid Injection			
Nerve Root Blocks			
Other Steroid Injections			
Chiropractic			
Hospital Bed rest			
Traction			
Psychology input, counselling			
Hypnosis			
Biofeedback			

Please continue below if you have trialled any other medications or pain management techniques.

When you are in pain, how often is your husband / wife / other family member supportive and encouraging ?

☐ Never ☐ Seldom ☐ Sometimes ☐ Frequently ☐ Always

When you are in pain, how often does your husband / wife / other family member ignore you or become angry ?

☐ Never ☐ Seldom ☐ Sometimes ☐ Frequently ☐ Always

How often has there been disharmony / conflict between you and your spouse, parent or children since the start of your pain ?

☐ Never ☐ Seldom ☐ Sometimes ☐ Frequently ☐ Always

Has your mood and temper changed since your pain started ?If so, how? What do other people say about your mood now?

_____

_____

Have any of your family members ever had a chronic pain problem ?

☐ Yes ☐ No If yes, who ? _____

What kind of pain ? _____

Have you ever experienced any <u>physical, emotional or sexual abuse</u> ?

☐ Yes ☐ No If yes, explain _____

_____

_____

Have you ever had <u>psychiatric, psychological, or social work evaluations</u> or treatments for any problem, including your current pain ?

☐ Yes ☐ No If yes, what and when ? _____

_____

How many standard drinks do you enjoy per day / week

☐ None ☐ I do enjoy _____ drinks per week

How many cigarettes do you smoke / day ?

☐ None ☐ I do smoke _____ cigarettes / day

Do you take any recreational drugs ?

☐ None ☐ Yes, I take _____

Have you ever smoked marijuana for your pain?

☐ None ☐ Yes ➔ If yes, what was the response ?

☐ It has reduced the pain without making me feel drugged

☐ It didn't change the pain but made me feel more relaxed

☐ Nothing happened ☐ The pain got worse

If you still use cannabis – how often? _____/ day/week (please circle)

Over the last 2 weeks, how often have you been bothered by any of the following problems
Mark the appropriate answer for question (1 answer per statement)

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down.				
Trouble concentrating on things, such as reading a newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ somewhat difficult ☐ Very difficult ☐ Extremely Difficult

In the last 3 months: Have you ever had thoughts of harming yourself to stop the pain?

☐ Yes ☐ No

If yes, who do you turn to in order to get help? _____

_____

_____

_____

_____

_____

_____

_____

Functional Status

☐ Independent ☐ Difficulty with balance ☐ Recent history of falls

☐ Need home help ☐ Live in nursing home ☐ Live in Hospice

Disabilities or impairments

☐ None ☐ Vision ☐ Hearing

☐ Mobility ☐ I need a wheelchair to move around

☐ Other _____

Aside from your pain problem, how is your general health (please check one) ?

☐ Excellent ☐ Minor Health Problems only ☐ Major Health Problems

Have you got any of the following health problems (please check all that apply)?

☐ High Blood Pressure
☐ Angina or chest pain
☐ Heart attack
☐ Kidney Problem
☐ Bowel problem
☐ TIA or Stroke
☐ Chronic cough
☐ Bleeding problem
☐ Arthritis
☐ Lung problem / Tuberculosis/Asthma
☐ Recent fall within the last 3 months

☐ Diabetes
☐ I have difficulties managing my diabetes
☐ Thyroid problems
☐ Liver disease
☐ Blood or clotting problem
☐ Seizure or epilepsy
☐ Cancer
☐ Stomach problem
☐ Need for antibiotics prior to procedures
☐ Recent change in ability to care for yourself
☐ Other _____

Have you undergone any operations linked to the pain problems you have ?

Date	Type of operation, Name of Surgeon & Hospital

The following are questions given to all patients at the Pain Management Clinic.

Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment.

Please answer the following questions using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

How often do you have mood swings? ___

How often have you felt a need for higher doses of medication to treat your pain? ___

How often have you felt impatient with your doctor ? ___

How often have you felt that things are just too overwhelming that you can' handle them ? ___

How often is there tension in the home ___

How often have you counted pain pills to see how many are remaining? ___

How often have you been concerned that people will judge you for taking pain medication? ___

How often do you feel bored? ___

How often have you taken more pain medication than you were supposed to? ___

How often have you worried about being left alone? ___

How often have you felt a craving for medication? ___

How often have others expressed concern over your use of medication? ___

How often have any of your close friends had a problem with alcohol or drugs? ___

How often have you felt consumed by the need to get pain medication? ___

How often have others told you that you had a bad temper? ___

How often have you run out of pain medication early? ___

How often have others kept you from getting what you deserve? ___

How often, in your lifetime, have you had legal problems or been arrested? ___

How often have you attended an AA or NA meeting? ___

How often have you been in an argument that was so out of control that someone got hurt? ___

How often have you been sexually abused? ___

How often have others suggested that you have a drug or alcohol problem? ___

How often have you had to borrow pain medications from your family or friends? ___

How often have you been treated for an alcohol or drug problem? ___

_____

What to do now ?

1. Please return the completed questionnaire to:
   Rotorua Pain Specialists Ltd; PO. Box 12083, Rotorua
   Alternatively fax the questionnaire to 07 3459921

2. As an ACC client you are covered by a contract I am holding with ACC. You do not need to seek prior approval by your case manager and we will deal with the funding of your assessment. However, we need the correct ACC claim number for the covered injury. Please contact me if you are uncertain if ACC will provide financial cover for your injury.

3. Please make an appointment with me
   by calling 07 – 3459915
   via email stephan.neff@painspecialists.co.nz

4. Please bring all available Xrays, letters and medical reports to your appointment

5. I will contact your GP and request that she/he sends us all information with regards to your current medications, recent blood tests as well as other health problems that may affect and alter the way we can help you managing your pain.

Thank you for your patience !

I am looking forward to meeting you in the near future !