Personal Details:

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
</table>

Contact Details:

Spinal Cord Injury (SCI) Details:

<table>
<thead>
<tr>
<th>Level of SCI:</th>
<th>Date of SCI:</th>
<th>Type of SCI:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete</td>
<td>□</td>
<td>□ Complete</td>
</tr>
<tr>
<td>Incomplete</td>
<td></td>
<td>□ Incomplete</td>
</tr>
</tbody>
</table>

(Complete AIS # (if known)
NB: If AIS unknown leave this column blank.

A □ Complete
B □ Incomplete
C □ Complete
D □ Incomplete

AIS describes the sensory & motor level of SCI according to the International Standards for the Neurological Classification of Spinal Cord Injury)

Health Screening Questions:

In the table below tick all that apply to your current pain problem:

- □ This is a new pain (pain in a new location or pain that has new characteristics)
- □ This is a significant flare up (or worsening) of an existing pain
- □ There has been a recent change in my level of sensation
- □ There has been a recent decrease in my muscle strength or function
- □ I have had a fever and / or chills
- □ I have noticed nausea, a lack of appetite and/or weight loss
- □ This pain causes me to have symptoms of Autonomic Dysreflexia
- □ I have noticed a recent change in my bladder function
  (may include symptoms of bladder infection, bladder leakage, difficulty emptying)
- □ I have noticed a recent change in my bowel function
  (may include constipation, bowel accidents, abdominal pain, bloating, rectal bleeding)
- □ I have a current area of skin breakdown
- □ I have had a recent fall or trauma
- □ There has been an increase in my muscle spasms

Discuss ticked items with your Doctor or Health Professional as soon as possible

THE SPINAL CORD INJURY PAIN QUESTIONNAIRE

Date: ____/____/_______
### THE SPINAL CORD INJURY PAIN QUESTIONNAIRE

1. Have you had any pain during the last 7 days including today? *
   - Yes
   - No

2. In general, how much has pain interfered with your day-to-day activities in the last week? *
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   (where 0 = no interference and 10 = extreme interference)

3. In general, how much has pain interfered with your overall mood in the last week? *
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   (where 0 = no interference and 10 = extreme interference)

4. In general, how much has pain interfered with your ability to get a good night’s sleep? *
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   (where 0 = no interference and 10 = extreme interference)

5. How many different pain problems do you have? *
   - 1
   - 2
   - 3
   - 4
   - ≥ 5

6. Average pain intensity in the past week?
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   (where 0 = no pain and 10 = pain as bad as you can imagine)

6. Where is the pain located?

7. Is the pain above or below your level of SCI? **
   - Above
   - Below

8. Is the pain in a region of reduced sensation? **
   - Yes
   - No

9. When did the pain start?  (Date of onset*)
   - ____/____/_____

10. Was there an event that triggered the pain?
    - Yes
    - No
    Details: __________________________

11. What words best describe your pain? **
    (tick all that apply)
    - Aching
    - Burning
    - Dull
    - Icy cold
    - Cramping
    - Electric Shocks
    - Tender
    - Pins & Needles
    - Squeezing
    - Tingling
    - Sharp
    - Other: ___________

12. How does pain change over the course of the day?

---

** Questions to help identify SCI Pain Type - International Spinal Cord Injury Pain Classification (Bryce et al 2012)
13. What makes the pain feel worse? **
- Personal care
- Mobility - transfers
- Mobility – wheelchair
- Mobility – walking
- Exercise/recreation/ sport
- Spasm
- Other: ______________
- Fatigue
- Stress
- Anxiety
- Constipation
- Bloating
- Bladder infection
- Other: __________

14. What makes the pain feel better? **
- Rest
- Position/posture change
- Activity Pacing
- Other: __________
- Medications
- Distraction
- Exercise

15. What medications do you use for pain?

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Helpful?</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>Y</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

16. Are you using or receiving any treatments for your pain problem? □ Y □ N

17. Treatment Details:


If you have more than one pain problem, please download the additional pages of the questionnaire and repeat these questions for your 2nd and 3rd worst pain.
### THE SPINAL CORD INJURY
PAIN QUESTIONNAIRE

For your second worst pain, provide the following details:

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where is the pain located?</td>
<td></td>
</tr>
<tr>
<td>Is the pain above or below your level of SCI? **</td>
<td>□ Above □ Below</td>
</tr>
<tr>
<td>Is the pain in a region of reduced sensation? **</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>When did the pain start? (Date of onset*)</td>
<td><em><strong><strong>/</strong></strong></em>/_______</td>
</tr>
<tr>
<td>Was there an event that triggered the pain? **</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Details:</td>
<td></td>
</tr>
<tr>
<td>What words best describe your pain? ** (tick all that apply)</td>
<td>□ Aching □ Burning</td>
</tr>
<tr>
<td>□ Dull □ Icy cold □ Cramping □ Electric Shocks □ Tender □ Tingling □ Squeezing □ Sharp □ Other: _______</td>
<td></td>
</tr>
<tr>
<td>How does pain change over the course of the day?</td>
<td></td>
</tr>
<tr>
<td>What makes the pain feel worse? **</td>
<td>□ Personal care □ Fatigue</td>
</tr>
<tr>
<td>□ Mobility - transfers □ Mobility – wheelchair □ Mobility – walking □ Exercise/recreation □ Spasm □ Other: _______ □ Stress □ Anxiety □ Constipation □ Bloating □ Bladder infection □ Other: _______</td>
<td></td>
</tr>
<tr>
<td>What makes the pain feel better? **</td>
<td>□ Rest □ Medications</td>
</tr>
<tr>
<td>□ Position change □ Activity Pacing □ Exercise □ Distraction □ Exercise □ Other: _______</td>
<td></td>
</tr>
<tr>
<td>What medications or treatments are used?</td>
<td></td>
</tr>
</tbody>
</table>
For your third worst pain, provide the following details:

<table>
<thead>
<tr>
<th>Question</th>
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<tbody>
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<td>Where is the pain located?</td>
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<tr>
<td>Is the pain in a region of reduced sensation? **</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>When did the pain start? (Date of onset*)</td>
<td>_____ / _____ / ______</td>
</tr>
<tr>
<td>Was there an event that triggered the pain?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Details:</td>
<td></td>
</tr>
<tr>
<td>What words best describe your pain? ** (tick all that apply)</td>
<td>□ Aching □ Burning □ Dull □ Icy cold □ Cramping □ Electric Shocks □ Tender □ Pins &amp; Needles □ Squeezing □ Tingling □ Sharp □ Other: _________</td>
</tr>
<tr>
<td>How does pain change over the course of the day?</td>
<td></td>
</tr>
<tr>
<td>What makes the pain feel worse? **</td>
<td>□ Personal care □ Fatigue □ Mobility - transfers □ Stress □ Mobility – wheelchair □ Anxiety □ Mobility – walking □ Constipation □ Exercise/recreation □ Bloating □ Spasm □ Bladder infection □ Other: __________ □ Other:________</td>
</tr>
<tr>
<td>What makes the pain feel better? **</td>
<td>□ Rest □ Medications □ Position change □ Distraction □ Activity Pacing □ Exercise □ __________ □ __________</td>
</tr>
<tr>
<td>What medications or treatments are used?</td>
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