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| **Pain Update** |

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| **Family name (surname):** | **Given name(s):** | **Today’s date:**  \_ \_ / \_ \_ / \_ \_ \_ \_ |
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| In the past week, on average, how would you rate your pain? |
|  | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |  |
| No pain |  |  |  |  |  |  |  |  |  |  | Pain as bad as you can imagine |

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| In the past week, how much has pain has interfered with your **daily activities?** |
|  | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |  |
| Does not interfere |  | Completely interferes |
| How much has each statement below applied to you over the past week? | Not at all | To some degree, or some of the time | To a considerable degree, or a good part of the time | Very much, or most of the time |
| I was aware of dryness of my mouth |  0 | 1 | 2 | 3 |
| I felt that I had nothing to look forward to |  0 | 1 | 2 | 3 |
| I felt I was close to panic |  0 | 1 | 2 | 3 |
| I was unable to become enthusiastic about anything |  0 | 1 | 2 | 3 |
| I felt I wasn’t worth much as a person |  0 | 1 | 2 | 3 |
| I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat) |  0 | 1 | 2 | 3 |

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| Please rate how confident you are that you can do the following things at present **despite the pain**.  |
| I can do some form of work, despite the pain (“work” includes housework, paid and unpaid work) | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Not at all confident | Completely confident |
| I can live a normal lifestyle, despite the pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Not at all confident | Completely confident |
| 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 |
| It’s terrible and I think it’s never going to get any better | 0 | 1 | 2 | 3 | 4 |
| I become afraid that the pain will get worse | 0 | 1 | 2 | 3 | 4 |
| I can’t seem to keep it out of my mind | 0 | 1 | 2 | 3 | 4 |
| I keep thinking about how badly I want the pain to stop | 0 | 1 | 2 | 3 | 4 |
| How many hours of paid work did you do in the last week? | …………………..hours |
| How many times in the last **3 months** have you **….** |
| …. visited a hospital emergency department because of your pain? | …………………. times |
| …. been admitted to hospital as an inpatient because of your pain | …………………. times |
| Please list all of the medications you are taking (include all 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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