University Hospitals of
Morecambe Bay
NHS Foundation Trust

Pain Management Patient Questionnaire

Your Name ………………………………….
Your Date of Birth …..………………….. Date: ……/……/………..

Dear Patient,

As part of the Pain Management Services, can we request you to complete this set of questions.

Why do I need to complete these questions?

This will help us to understand your pain and its effect on your life. Completing these questions will also generate a data set to analyse and improve the care we provide.

Who will see the answers I give?

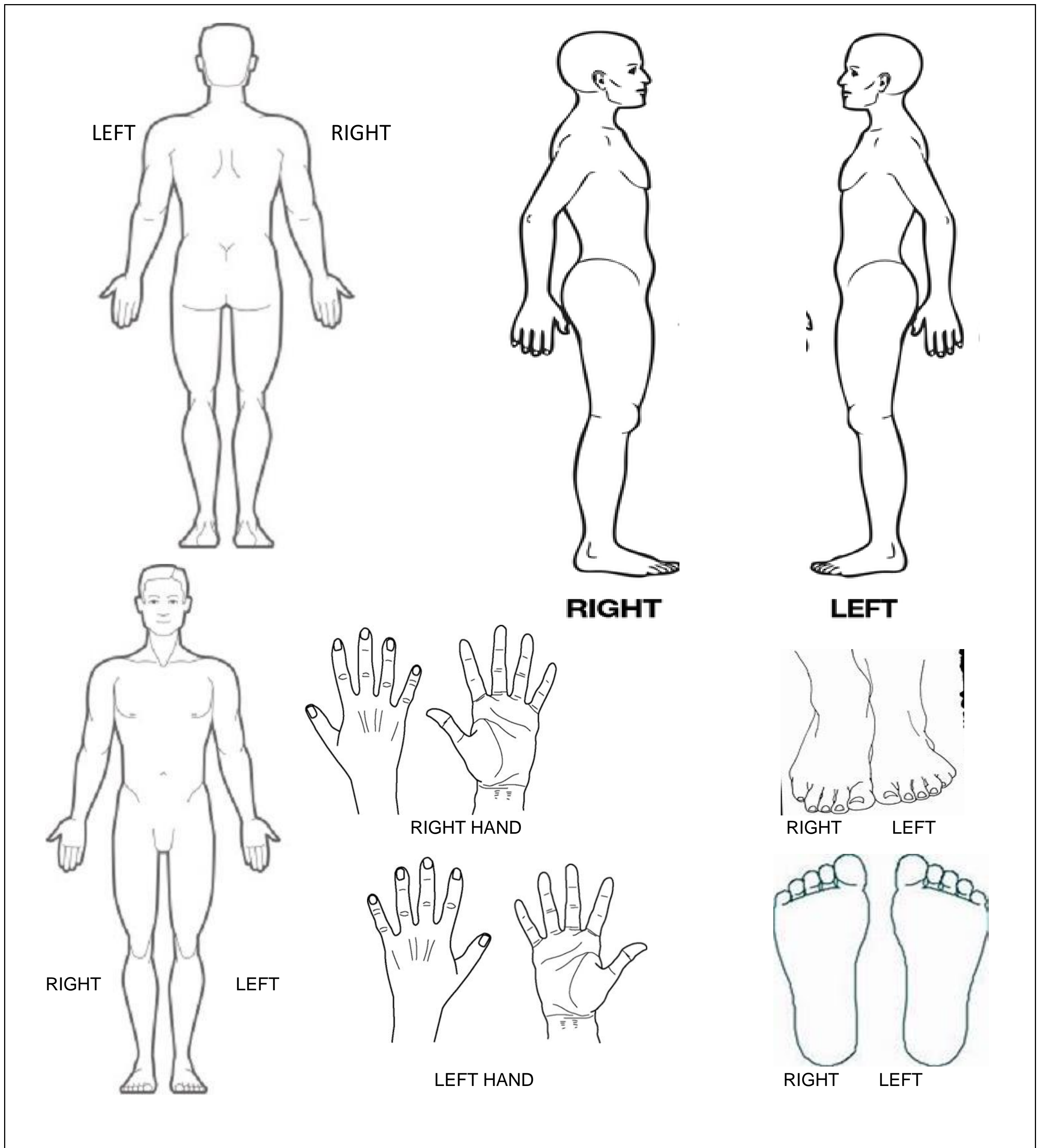
Your answers will be a part of your confidential health record, so will be accessed by the health care professionals when deemed necessary. Please do not hesitate to contact us if you have any queries about how the information that you provide will be used.

Completing the questions

- Please try to answer every question. If you feel that you cannot answer a question then leave it blank and discuss it with your Pain Management Team.
- If you feel that more than one score option fits your experience, please score the highest option.
- **If you feel that you need help, please contact our Pain Management Team on 01539715147 (Monday to Friday between 9AM and 4PM)**

Pain Drawing - Please mark on the drawing where you feel these sensations using the symbols:

Pain	xxxx	Cramping	////
Numbness or Pins and Needles	oooo	Burning or Hot Areas	zzzz



Please briefly describe your pain

……

……

1. Circle a number below to indicate the intensity of your pain: e.g. **0 = No Pain 10 = Worst Pain**

a) Right Now

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

b) At its worst in the last week

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

c) At its best in the last week

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

2. How long have you been suffering from pain? …….. Years ………. Months

3. How did it start (please tick more than one if appropriate)
   a. Following an accident ❑
   b. Following a surgery ❑
   c. Unknown, Gradual onset ❑
   d. Following an illness ❑
   e. Other ❑ (Please describe) ……………………………………………………………

4. What makes your pain worse?

……

5. What makes your pain better or more manageable?

……

6. What medications do you use to manage your Pain?

……

7. Circle the number that describes how during the past week, PAIN HAS INTERFERED with your life **(0 being the Least** and **10 being the Worst):**

a. Relationship with other

0 1 2 3 4 5 6 7 8 9 10

b. Sleep

0 1 2 3 4 5 6 7 8 9 10

c. Mood

0 1 2 3 4 5 6 7 8 9 10

8. I, despite my Pain, can - **(0 being Not Confident to 10 being Fully confident)**

   a. Live a normal Life style

   0 1 2 3 4 5 6 7 8 9 10

   b. Do some work (incl. professional, voluntary and housework)

   0 1 2 3 4 5 6 7 8 9 10

   c. Enjoy my hobbies

   0 1 2 3 4 5 6 7 8 9 10

9. Chronic pain can often make people feel anxious and stressed or experience low mood. Is this something you experience? If so, please describe briefly (If NO, Please jump to Q 11)

   ………

10. Have you ever needed, or are you currently undergoing any mental health team input? If so, please describe briefly

   ………

11. Could you tell us about your mobility or walking:
   Please tick the one that applies to you

   - ❑ My pain does not affect my walking
   - ❑ I can walk without aids but the distance is limited due to pain
   - ❑ I can only walk using aids such as a stick or crutches
   - ❑ I can only walk using a walking frame or wheeled walker
   - ❑ I depend on a wheelchair or mobility scooter

12. What is your Health Score Today?
   (0 = the Worst Health you can imagine and 10 = the Best Health you can imagine)

   0 1 2 3 4 5 6 7 8 9 10

Worst Health Best Health

Thank You for your time and cooperation to complete this questionnaire.

We will get back to you shortly

Please return the filled questionnaire to: Office for Secretaries, Dept. of Pain Management, Westmorland General Hospital, Burton Road, Kendal, LA9 7RG