KAISER PERMANENTE®

Chronic Pain Management MR#: _____

Pain Assessment Questionnaire Name: _____

INFORMATION ABOUT YOUR PAIN PROBLEM

1. What is your main reason for coming to the pain clinic today?

   _____

2. How long have you been in pain? _____

3. Briefly describe how your pain started? _____

4. Do you have any of the following with your pain?

   Tingling/numbness in the hands/feet ◯ Yes ◯ No

   Weakness in the hands/feet ◯ Yes ◯ No

   Difficulty holding bladder or bowel movement ◯ Yes ◯ No

5. What triggers or makes your pain worse? _____

6. What do you do to ease or relieve your pain? _____

TREATMENTS YOU HAVE TRIED

7. Which of the following treatments have you tried for your pain condition and what was the result?

	Check box if yes	If yes, was it helpful?
Acupuncture	☐ Yes	◯ Yes ◯ No
Biofeedback	☐ Yes	◯ Yes ◯ No
Exercise	☐ Yes	◯ Yes ◯ No
Herbal remedies	☐ Yes	◯ Yes ◯ No
Nerve block/epidural	☐ Yes	◯ Yes ◯ No
Physical therapy	☐ Yes	◯ Yes ◯ No
Psychotherapy	☐ Yes	◯ Yes ◯ No
Relaxation training	☐ Yes	◯ Yes ◯ No
TENS Unit	☐ Yes	◯ Yes ◯ No
Other:	☐ Yes	◯ Yes ◯ No
Surgery	☐ Yes	◯ Yes ◯ No
Chronic Pain Management Program	☐ Yes	◯ Yes ◯ No

PERSONAL AND FAMILY HISTORY

8. Who lives with you? (Check as many as apply)

   ☐ Live alone ☐ Spouse/partner ☐ Parents ☐ Roommate ☐ Children, ages_____ ☐ Pets

9. Do you feel supported at home? ◯ Yes ◯ No

10. Are you currently experiencing any stressful situations?

    Stress at work ◯ Yes ◯ No Financial stress ◯ Yes ◯ No

    Stress with your family ◯ Yes ◯ No Stress with your friends ◯ Yes ◯ No

11. Have you experienced or undergone treatment for any of the following? Please check all that apply.

☐ Depression ☐ Anxiety ☐ PTSD ☐ ADD/ADHD ☐ OCD ☐ Other: _____

12. Do you have any blood relatives (immediate family) with a history of any of the following? (check as many as apply):

☐ Chronic pain ☐ Alcoholism/drug abuse ☐ Depression ☐ Headache
☐ Suicide ☐ Disability ☐ Mental illness

13. What is your work status? ◯ Working full-time ◯ Working part-time ◯ Not working

14. Which of the follow, if any, apply to your pain condition?

	Active/Open	Settled/Closed	Considering
Disability claim	◯	◯	◯
Worker's Compensation	◯	◯	◯
Litigation (lawsuit)	◯	◯	◯

INFORMATION ABOUT YOUR HABITS

15. In a typical week, how many caffeinated drinks do you have per day? _____

16. In a typical week, how many drinks containing alcohol do you have? _____
_____ drinks per day on _____ days per week.

17. Have you ever participated in a substance abuse treatment program? ◯ Yes ◯ No

18. Do you use tobacco? (cigarettes, cigars, chewing tobacco, pipe, nicotine replacement)
◯ Yes. Amount per day? _____ Number of years? _____
◯ No

19. Are you currently using any cannabis products? ◯ Yes ◯ No

INFORMATION ABOUT YOUR SLEEP

20. Please check any that apply to you:

☐ I have trouble falling asleep
☐ I have trouble staying asleep
☐ I feel refreshed when I wake up

Additional comments or more information that you feel is relevant to your pain condition:

_____

_____

_____

_____

KAISER PERMANENTE®

Name: _____

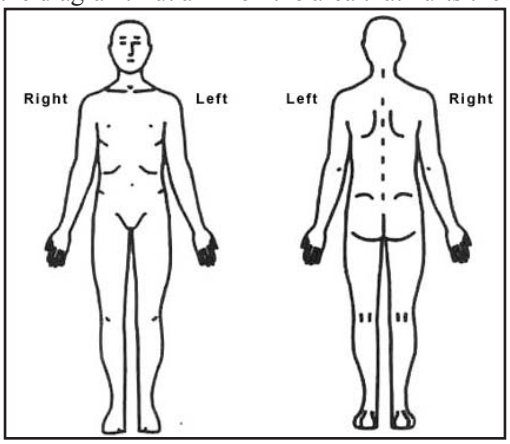
MR#: _____

Imprint Area

BRIEF PAIN INVENTORY

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and tooth-aches). Have you had pain other than these everyday kinds of pain today?
   ☐ Yes ☐ No

2. After printing this form, shade in the areas where you feel pain on the diagram. Put an X on the area that hurts the most.



3. Please rate your pain by checking the one number that best describes 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

4. Please rate your pain by checking the one number that best describes 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

5. Please rate your pain by checking the one number that best describes your pain on the AVERAGE.

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

No Pain — Pain as bad as you can imagine

6. Please rate your pain by checking the one number that tells how much pain you have RIGHT NOW.

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

No Pain — Pain as bad as you can imagine

7. What treatments or medications are you receiving for your pain?

   _____

   _____

8. In the last week, how much relief have pain treatments or medications provided? Please check the one percentage that shows how much RELIEF you have received.

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

9. Check the one number that describes how, during the past week, pain has interfered with your :

A. General activity

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

B. Mood

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

C. Walking ability

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

D. Normal work (includes both work outside the home and housework)

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

E. Relations with other people

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

F. Sleep

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

G. Enjoyment of life

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

KAISER PERMANENTE®

Name: _____

MR#: _____

Imprint Area

SOAPPÈ Version 1.0 - SF

Name: _____ **Date:** _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. 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. Thank you.

Please answer the questions below using the following scale:
0 = Never, 1 = Seldon, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?					
	0	1	2	3	4
2. How often do you smoke a cigarette within an hour after you wake?					
	0	1	2	3	4
3. How often have you taken medication other than the way that it was prescribed?					
	0	1	2	3	4
4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past fire years?					
	0	1	2	3	4
5. How often in your lifetime, have you had legal problems or been arrested?					
	0	1	2	3	4

Please include any additional information you wish about the above answers. Thank you.

KAISER PERMANENTE®

Name: _____

MR#: _____

AOQ 1.4

DATE _____

Imprint Area

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(check box to indicate your answer)*	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. 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	○	○	○	○
9. Thoughts that you would be better off dead, or of hurting yourself in some way	○	○	○	○

add columns			
A TOTAL:			

10. Feeling nervous, anxious, or on edge	○	○	○	○
11. Not being able to stop or control worrying	○	○	○	○
12. Feeling unproductive at work or other daily activities	○	○	○	○
13. Having trouble focusing on achieving your goals	○	○	○	○

add columns			
B TOTAL:			

Global Distress Score: TOTAL (A+B) = _____

GDS

Relationship Review

Many health problems can be affected by stress in your relationships. Making the connection can help you take steps toward better health.

1. Are you currently in a relationship where your partner hits, slaps, kicks, or hurts you?	○ Yes	○ No	○ Prefer not to answer
2. Are you currently in a relationship where you feel threatened by your partner?	○ Yes	○ No	○ Prefer not to answer
3. Have you ever had a partner who physically hurt or threatened you?	○ Yes	○ No	○ Prefer not to answer

KAISER PERMANENTE

Name: _____ Date: _____

Medical Record #: _____

Program Readiness Questions

Could your current work/life schedule accommodate multiple appointments in the Pain Management program?

◯ Yes ◯ No ◯ Unsure

If no, why not? _____

Have you accepted the idea that you may have a significant amount of pain for a long time, perhaps for the rest of your life?

◯ Yes ◯ No ◯ Unsure

Do you believe that our thoughts, emotions, and behaviors can influence your pain?

◯ Yes ◯ No ◯ Unsure

Are you ready to learn and practice (relaxation exercises, proper exercise, distracting your thoughts, etc.) self-management skills to cope better with your pain?

◯ Yes ◯ No ◯ Unsure

Are you ready to taper off any medications you currently taking that are **NOT RECOMMENDED** for the long term management of chronic pain?

◯ Yes ◯ No ◯ Unsure

PLEASE DO NOT ANSWER THE FOLLOWING TWO QUESTIONS UNTIL THE INSTRUCTORS DISCUSS.

1. What is your goal for participation in the program?

_____

_____

_____

2. How motivated are you to participate? 1 = not motivated and 10 = very motivated.
   Please check one

◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
1	2	3	4	5	6	7	8	9	10