Acute Services Division

Anaesthetic Department

Glasgow Unified Pain Form Part A: Patient Questionnaire

NHS Greater Glasgow and Clyde

Patient details

Hospital:

Name:.....

Address:.....

.....

D.o.B.:.....

Date:

Unit no:.....

Use address label if available.

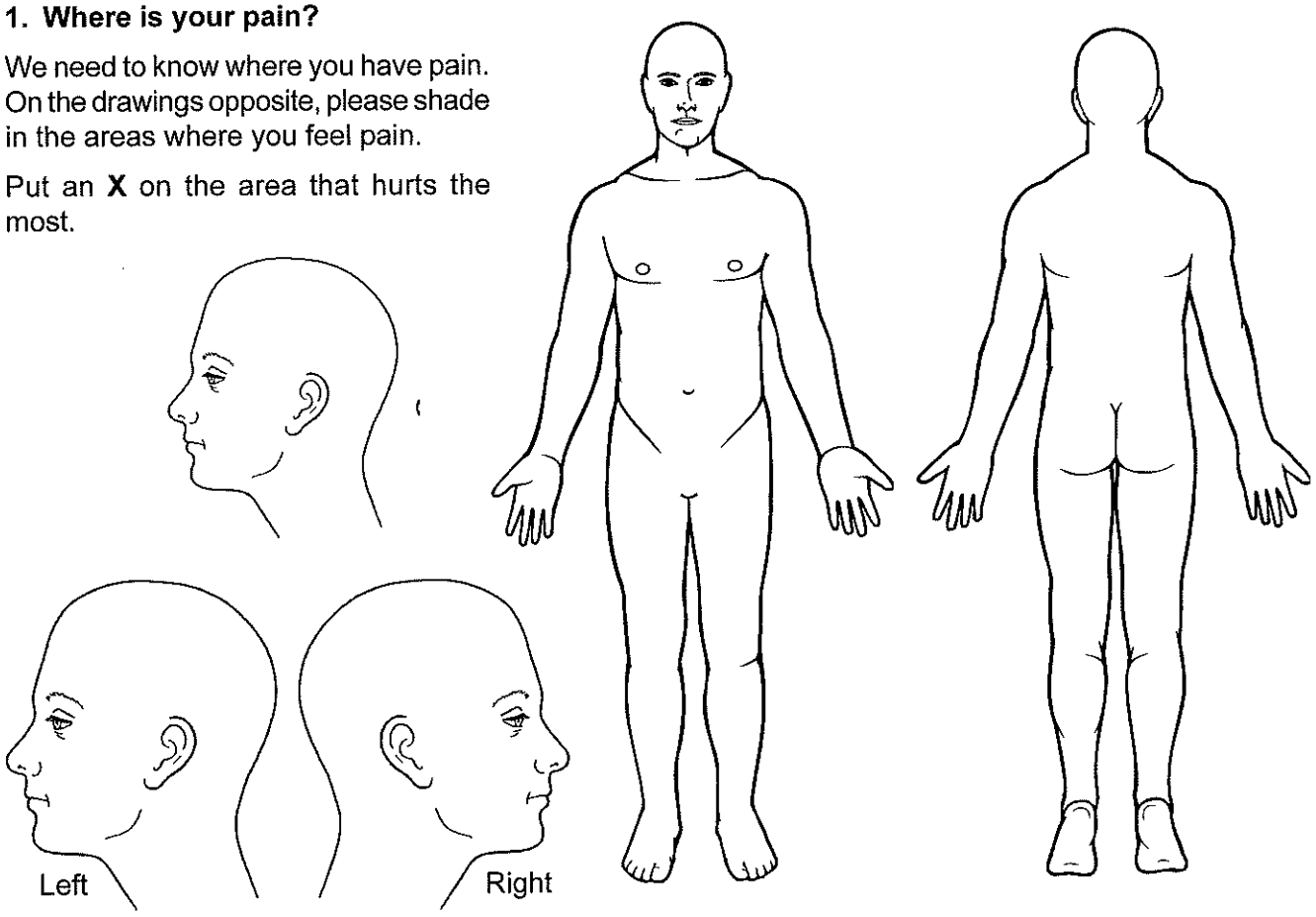
Please help us by filling in as much of the following questionnaire as you can.

Please bring the completed questionnaire with you when you come to hospital for your Pain Clinic appointment. Don't worry if you find some questions difficult, we will go over all the questions with you on your first visit to the clinic.

1. Where is your pain?

We need to know where you have pain. On the drawings opposite, please shade in the areas where you feel pain.

Put an **X** on the area that hurts the most.



CONFIDENTIALITY AND USE OF PATIENT'S INFORMATION

For the purpose of your present and future medical treatment, details of your medical care will be recorded. Some use may be made of this information for research purposes and to indicate the kind of future health services which patients may require; some will be processed on a computer. At all times great care is taken to ensure that high standards of confidentiality are maintained in respect of all information held. The "Data Protection Act 1998" gives you the right of access to any personal information which the Division may hold about you either in manual records or on its computers. If you wish to apply for access to your data, or if you would like more information about your rights under the Act, you should, in the first instance, contact the Health Records Officer at the hospital.

Please answer the following questions (Please use block capitals)

2. When did you start having problems with pain? If there was an accident or injury please describe it.

3. Pain is often very difficult to describe to others. Below is a list of words that people sometimes use when talking about their pain. Please circle any words that you feel describe your pain. You can add other words if you wish.

cutting	pounding	tingling	tiring	deep
beating	squeezing	throbbing	horrible	stabbing
burning	pulling	sickening	biting	screaming
scraping	aching	uncomfortable	cold	tugging
pricking	cruel	warm	miserable	stretching
pinching	unbearable	sad	itching	terrible
stinging	cool	sore	flashing	pressing
fearful	sharp	jumping	tight	pins and needles
hot	spreading	punishing	searing	lonely
bad				

4. When do you have your pain?

5. Is there anything that makes your pain worse?

6. Is there anything that helps your pain?

7. Please rate your pain by circling a number on the scales below. This will give us an idea of your pain level on average, at its worst and at its best.

The number 0 represents no pain at all, the number 10 represents the worst pain you could possibly have.

Please rate your pain **at its worst** in the past week...

No pain 0 1 2 3 4 5 6 7 8 9 10 **Worst pain possible**

Please rate your pain **at its best** in the past week...

No pain 0 1 2 3 4 5 6 7 8 9 10 **Worst pain possible**

Please rate your pain **on the average** for the past week...

No pain 0 1 2 3 4 5 6 7 8 9 10 **Worst pain possible**

Continues opposite

Please rate the pain you have **right now**...

No pain 0 1 2 3 4 5 6 7 8 9 10 **Worst pain possible**

8. Pain can sometimes interfere with our mood, our sleep, and the ability to do what we want to do.

Please rate how much your pain interferes with the following areas of your life, by circling a number between 0 and 10 on the scales below (0 = no interference, 10 = complete interference).

How much does your pain interfere with **your general activity**?

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **Completely interferes**

How much does your pain interfere with **your mood**?

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **Completely interferes**

How much does your pain interfere with **your walking ability**?

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **Completely interferes**

How much does your pain interfere with **your normal work**?

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **Completely interferes**

How much does your pain interfere with **your relationships with other people**?

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **Completely interferes**

How much does your pain interfere **with your sleep**?

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **Completely interferes**

How much does your pain interfere with **your enjoyment of life**?

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **Completely interferes**

Are there any **activities** (for example hobbies, socialising) you would like to do, which **your pain stops you from doing**?

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **Completely interferes**

Medicines

9. Please list all medicines you are taking just now, including doses. If you have a list of medications from your GP please bring that with you when you attend the Pain Clinic.

Name of medication	Dose	Times taken	Does it help?

10. Please list any other medicines you have taken <u>in the past</u> for your pain.

Name of medication	Did it help?	Why did you stop taking it?

11. Are there any medicines that you are allergic to? **Yes** ☐ **No** ☐

If 'Yes' please list these:

12. Have you tried any other types of treatment (apart from conventional medicines) for your pain?

Name of treatment	Was it helpful?

Finally, what do you hope to get from your visit to the Pain Clinic, and what would you like us to do to help you?

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