Questionnaire Pack

IF YOU ARE EXPERIENCING PAIN, please complete ALL questionnaires in the pack

IF YOU DO NOT HAVE PAIN, please only complete the Euroquol, GAD-7, PHQ-9, MSPSS, OHIP-14 and PCL

If you are completing hard copies of the questionnaires and do not have pain, please only complete those questionnaires up to the green sheet.

Thank you for your time.

Under each heading, please tick the ONE box that best describes your health TODAY

MOBILITY

I have no problems in walking about ☐
I have slight problems in walking about ☐
I have moderate problems in walking about ☐
I have severe problems in walking about ☐
I am unable to walk about ☐

SELF-CARE

I have no problems washing or dressing myself ☐
I have slight problems washing or dressing myself ☐
I have moderate problems washing or dressing myself ☐
I have severe problems washing or dressing myself ☐
I am unable to wash or dress myself ☐

USUAL ACTIVITIES *(e.g. work, study, housework, family or leisure activities)*

I have no problems doing my usual activities ☐
I have slight problems doing my usual activities ☐
I have moderate problems doing my usual activities ☐
I have severe problems doing my usual activities ☐
I am unable to do my usual activities ☐

PAIN / DISCOMFORT

I have no pain or discomfort ☐
I have slight pain or discomfort ☐
I have moderate pain or discomfort ☐
I have severe pain or discomfort ☐
I have extreme pain or discomfort ☐

ANXIETY / DEPRESSION

I am not anxious or depressed ☐
I am slightly anxious or depressed ☐
I am moderately anxious or depressed ☐
I am severely anxious or depressed ☐
I am extremely anxious or depressed ☐

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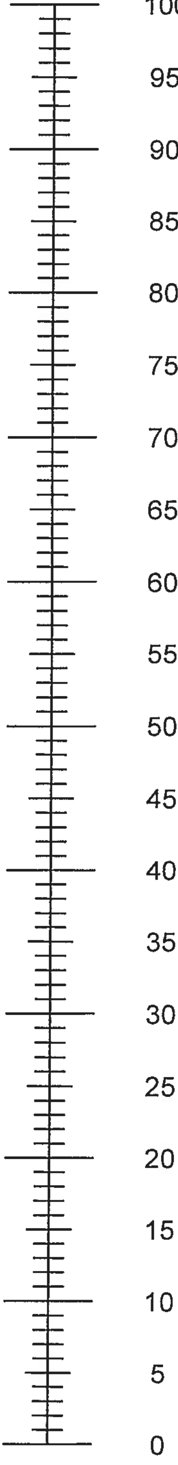
The best health you can imagine



The worst health you can imagine

- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
  0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY = ☐

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GAD-7

Identifier [ ] Date [ ]

Please read each statement and record a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past two weeks. There are no right or wrong answers. Do not spend too much time on any one statement. This assessment is not intended to be a diagnosis. If you are concerned about your results in any way, please speak with a qualified health professional.

0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day

1	Feeling nervous, anxious or on edge	
2	Not being able to stop or control worrying	
3	Worrying too much about different things	
4	Trouble relaxing	
5	Being so restless that it is hard to sit still	
6	Becoming easily annoyed or irritable	
7	Feeling afraid as if something awful might happen	

Total GAD-7 score =

Privacy - please note - this form neither saves nor transmits any information about you or your assessment scores. If you wish to keep your results you will need to print this document. These results are intended as a guide to your health and are presented for educational purposes only. They are not intended to be a clinical diagnosis. If you are concerned in any way about your health, please consult with a qualified health professional.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:______________________________ DATE:______________

Over the last *2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	________
Somewhat difficult	________
Very difficult	________
Extremely difficult	________

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A2663B 10-04-2005

Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet & Farley, 1988)

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you **Very Strongly Disagree**
Circle the "2" if you **Strongly Disagree**
Circle the "3" if you **Mildly Disagree**
Circle the "4" if you are **Neutral**
Circle the "5" if you **Mildly Agree**
Circle the "6" if you **Strongly Agree**
Circle the "7" if you **Very Strongly Agree**

1.	There is a special person who is around when I am in need.	1	2	3	4	5	6	7	SO
2.	There is a special person with whom I can share my joys and sorrows.	1	2	3	4	5	6	7	SO
3.	My family really tries to help me.	1	2	3	4	5	6	7	Fam
4.	I get the emotional help and support I need from my family.	1	2	3	4	5	6	7	Fam
5.	I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7	SO
6.	My friends really try to help me.	1	2	3	4	5	6	7	Fri
7.	I can count on my friends when things go wrong.	1	2	3	4	5	6	7	Fri
8.	I can talk about my problems with my family.	1	2	3	4	5	6	7	Fam
9.	I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7	Fri
10.	There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7	SO
11.	My family is willing to help me make decisions.	1	2	3	4	5	6	7	Fam
12.	I can talk about my problems with my friends.	1	2	3	4	5	6	7	Fri

The items tended to divide into factor groups relating to the source of the social support, namely family (Fam), friends (Fri) or significant other (SO).

OHIP-14

On the next page, we would like you to tell us how often you have had problems with your mouth, teeth, or gums in the last 3 months:

	Never	Hardly ever	Occasionally	Fairly often	Very often
1. Have you had trouble pronouncing any words because of problems with your teeth, mouth or dentures?	☐	☐	☐	☐	☐
2. Have you felt that your sense of taste worsened because of problems with your teeth, mouth or dentures?	☐	☐	☐	☐	☐
3. Have you had painful aching in your mouth?	☐	☐	☐	☐	☐
4. Have you found it uncomfortable to eat any foods because of problems with your teeth, mouth or dentures?	☐	☐	☐	☐	☐
5. Have you been self-conscious because of problems with your teeth, mouth or dentures?	☐	☐	☐	☐	☐
6. Have you felt tense because of problems with your teeth, mouth or dentures?	☐	☐	☐	☐	☐
7. Has your diet been unsatisfactory because of problems with your teeth, mouth or dentures?	☐	☐	☐	☐	☐
8. Have you had to interrupt meals because of problems with your teeth, mouth or dentures?	☐	☐	☐	☐	☐
9. Have you found it hard to relax because of problems with your teeth, mouth or dentures?	☐	☐	☐	☐	☐
10. Have you been a bit embarrassed because of problems with your teeth, mouth or dentures?	☐	☐	☐	☐	☐
11. Have you been irritable with other people because of problems with your teeth, mouth or dentures?	☐	☐	☐	☐	☐
12. Have you had difficulty doing your usual jobs because of problems with your teeth, mouth or dentures?	☐	☐	☐	☐	☐
13. Have you felt that life in general was less satisfying because of problems with your teeth, mouth or dentures?	☐	☐	☐	☐	☐
14. Have you been totally unable to function because of problems with your teeth, mouth or dentures?	☐	☐	☐	☐	☐

PCL (Brief version)

Patient name:____________________________________ **Date:**____________

Instructions: Below is a list of problems and complaints which people may experience after a nerve injury. Please read each one carefully, then **circle** one of the numbers to the right to indicate how much you have been **bothered** by the problem.

BOTHERED BY	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Avoiding activities or situations because they remind you of the experience?	1	2	3	4	5
2. Loss of interest in activities that you used to enjoy?	1	2	3	4	5
3. Feeling distant or cut off from other people?	1	2	3	4	5
4. Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5
5. Trouble falling or staying asleep?	1	2	3	4	5
6. Being jumpy or easily startled?	1	2	3	4	5

IF YOU HAVE PAIN, PLEASE CONTINUE WITH ANSWERING THE FOLLOWING QUESTIONNAIRES.

IF YOU DO NOT HAVE PAIN, PLEASE STOP HERE. THANK YOU.

A.1. Chronic Pain Acceptance Questionnaire–8 (CPAQ-8)

Directions: Below you will find a list of statements. Please rate the truth of each statement as it applies to you by circling a number. Use the following rating scale to make your choices. For instance, if you believe a statement is "Always True", you would circle the 6 next to that statement.

Never true	Very rarely true	Seldom true	Sometimes true	Often true	Almost always true	Always true
0	1	2	3	4	5	6

1. I am getting on with the business of living no matter what my level of pain is	0	1	2	3	4	5	6
2. Keeping my pain level under control takes first priority whenever I am doing something	0	1	2	3	4	5	6
3. Although things have changed, I am living a normal life despite my chronic pain	0	1	2	3	4	5	6
4. Before I can make any serious plans, I have to get some control over my pain	0	1	2	3	4	5	6
5. I lead a full life even though I have chronic pain	0	1	2	3	4	5	6
6. When my pain increases, I can still take care of my responsibilities	0	1	2	3	4	5	6
7. I avoid putting myself in situations where my pain might increase	0	1	2	3	4	5	6
8. My worries and fears about what pain will do to me are true	0	1	2	3	4	5	6

Note. Pain willingness scale = Items 2, 4, 7 and 8 (reverse scored), activity engagement scale = Items 1, 3, 5 and 6, total = activity engagement + pain willingness.

Short-Form McGill Pain Questionnaire–2 (SF-MPQ-2)

This questionnaire provides you with a list of words that describe some of the different qualities of pain and related symptoms. Please put an X through the numbers that best describe the intensity of each of the pain and related symptoms you felt during the past week. Use 0 if the word does not describe your pain or related symptoms.

Item														
1. Throbbing pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
2. Shooting pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
3. Stabbing pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
4. Sharp pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
5. Cramping pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
6. Gnawing pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
7. Hot-burning pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
8. Aching pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
9. Heavy pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
10. Tender	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
11. Splitting pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
12. Tiring-exhausting	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
13. Sickening	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
14. Fearful	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
15. Punishing-cruel	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
16. Electro-shock pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
17. Cold-freezing pain	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
18. Piercing	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
19. Pain caused by light touch	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
20. Itching	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
21. Tingling or "pins and needles"	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*
22. Numbness	*none*	0	1	2	3	4	5	6	7	8	9	10	*worst possible*

PAIN QUESTIONNAIRE

Date: ______ Patient: **Last name:** ______ **First name:** ______

How would you assess your pain **now**, at this moment?

0	1	2	3	4	5	6	7	8	9	10

none ... max.

How strong was the **strongest** pain during the past 4 weeks?

0	1	2	3	4	5	6	7	8	9	10

none ... max.

How strong was the pain during the past 4 weeks **on average**?

0	1	2	3	4	5	6	7	8	9	10

none ... max.

Mark the picture that best describes the course of your pain:

- Persistent pain with slight fluctuations ☐
- Persistent pain with pain attacks ☐
- Pain attacks without pain between them ☐
- Pain attacks with pain between them ☐

Please mark your **main area of pain**

Does your pain radiate to other regions of your body? yes ☐ no ☐

If yes, please draw the direction in which the pain radiates.

Do you suffer from a burning sensation (e.g., stinging nettles) in the marked areas?

never ☐ hardly noticed ☐ slightly ☐ moderately ☐ strongly ☐ very strongly ☐

Do you have a tingling or prickling sensation in the area of your pain (like crawling ants or electrical tingling)?

never ☐ hardly noticed ☐ slightly ☐ moderately ☐ strongly ☐ very strongly ☐

Is light touching (clothing, a blanket) in this area painful?

never ☐ hardly noticed ☐ slightly ☐ moderately ☐ strongly ☐ very strongly ☐

Do you have sudden pain attacks in the area of your pain, like electric shocks?

never ☐ hardly noticed ☐ slightly ☐ moderately ☐ strongly ☐ very strongly ☐

Is cold or heat (bath water) in this area occasionally painful?

never ☐ hardly noticed ☐ slightly ☐ moderately ☐ strongly ☐ very strongly ☐

Do you suffer from a sensation of numbness in the areas that you marked?

never ☐ hardly noticed ☐ slightly ☐ moderately ☐ strongly ☐ very strongly ☐

Does slight pressure in this area, e.g., with a finger, trigger pain?

never ☐ hardly noticed ☐ slightly ☐ moderately ☐ strongly ☐ very strongly ☐

(To be filled out by the physician)

never	hardly noticed	slightly	moderately	strongly	very strongly
☐ x 0 = 0	☐ x 1 = ☐	☐ x 2 = ☐☐	☐ x 3 = ☐☐	☐ x 4 = ☐☐	☐ x 5 = ☐☐

Total score ☐☐ out of 35

R. Freynhagen, R. Baron, U. Gockel, T.R. Tölle, Current Medical Research and Opinion vol 22 (10) 2006; 1911-1920

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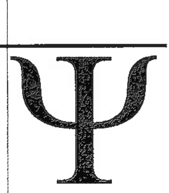

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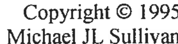

PCS-EN

Client No.: __________ Age: _____ Sex: M(__) F(__) Date: _______________

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

0 – not at all **1** – to a slight degree **2** – to a moderate degree **3** – to a great degree **4** – all the time

When I'm in pain …

1 ☐ I worry all the time about whether the pain will end.

2 ☐ I feel I can't go on.

3 ☐ It's terrible and I think it's never going to get any better.

4 ☐ It's awful and I feel that it overwhelms me.

5 ☐ I feel I can't stand it anymore.

6 ☐ I become afraid that the pain will get worse.

7 ☐ I keep thinking of other painful events.

8 ☐ I anxiously want the pain to go away.

9 ☐ I can't seem to keep it out of my mind.

10 ☐ I keep thinking about how much it hurts.

11 ☐ I keep thinking about how badly I want the pain to stop.

12 ☐ There's nothing I can do to reduce the intensity of the pain.

13 ☐ I wonder whether something serious may happen.

…Total

PAIN SELF EFFICACY QUESTIONNAIRE (PSEQ)

M.K.Nicholas (1989)

NAME: ______________________ DATE: ______________

Please rate how **confident** you are that you can do the following things at present, **despite the pain**. To indicate your answer circle **one** of the numbers on the scale under each item, where 0 = not at all confident and 6 = completely confident.

For example:

0	1	2	3	4	5	6
Not at all Confident						**Completely confident**

Remember, this questionnaire is **not** asking whether of not you have been doing these things, but rather **how confident you are that you can do them at present, despite the pain.**

---

1. **I can enjoy things, despite the pain.**

0	1	2	3	4	5	6
Not at all Confident						**Completely confident**

2. **I can do most of the household chores (e.g. tidying-up, washing dishes, etc.), despite the pain.**

0	1	2	3	4	5	6
Not at all Confident						**Completely confident**

3. **I can socialise with my friends or family members as often as I used to do, despite the pain.**

0	1	2	3	4	5	6
Not at all Confident						**Completely confident**

4. **I can cope with my pain in most situations.**

0	1	2	3	4	5	6
Not at all Confident						**Completely confident**

Turn over

5. 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

6. I can still do many of the things I enjoy doing, such as hobbies or leisure activity, despite pain.

0	1	2	3	4	5	6
Not at all Confident						Completely confident

7. I can cope with my pain without medication.

0	1	2	3	4	5	6
Not at all Confident						Completely confident

8. I can still accomplish most of my goals in life, despite the pain.

0	1	2	3	4	5	6
Not at all Confident						Completely confident

9. I can live a normal lifestyle, despite the pain.

0	1	2	3	4	5	6
Not at all Confident						Completely confident

10. I can gradually become more active, despite the pain.

0	1	2	3	4	5	6
Not at all Confident						Completely confident

Source: Nicholas M.K. Self-efficacy and chronic pain. Paper presented at the annual conference of the British Psychological Society. St. Andrews, 1989.
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