PEDIATRIC PAIN QUESTIONNAIRE

Form A (Adolescent)

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The purpose of this questionnaire is to help us obtain a comprehensive history of your pain problems. All information obtained from this questionnaire and in interviews will remain strictly confidential. If you do not wish to answer a particular question, for any reason, please write "do not wish to answer" in the space provided. Please print or write clearly.

Today's Date: _____

Your Name: _____

Age: _____ Date of Birth: _____

Grade in School: _____ Name of School_____

Place of Work: _____

Address: _____

_____

Phone number: _____

When did your present pain problem begin? Please explain the symptoms, exact locations of pain and whether the pain has been on or off over the months and years.

_____

_____

_____

_____

_____

What was your reaction to the pain at the time? Please explain.

_____

_____

Were any major changes in your life occurring then? Please explain.

_____

_____

Is your current pain constant or does it seem to come and go?

_____

_____

Is your pain accompanied by nausea, vomiting, dizziness, feeling faint, anxiety, rapid breathing or other symptoms? If so, please list the symptoms.

_____

_____

If your pain were suddenly to disappear, how would it change your life?

_____

_____

_____

If your pain were to suddenly disappear, how would it change your family relationships?

Assuming that the discomfort continues, what kinds of things do you think you should DO now, which will help you later on?

Is there anything else you would like to tell us about your discomfort and the effect it has on yourself or your family?

What words would you use to describe your discomfort?

From the words listed below, circle the ones that describe the way it feels when you are in pain.

Cutting	Pounding	Tingling	Tiring	Deep
Beating	Squeezing	Throbbing	Horrible	Stabbing
Burning	Pulling	Sickening	Biting	Screaming
Scraping	Aching	Uncomfortable	Cold	Tugging
Pricking	Unbearable	Sad	Itching	Terrible
Stinging	Cool	Sore	Flashing	Pressing
Fearful	Pins & needles	Sharp	Jumping	Tight
Hot	Spreading	Punishing	Scared	Lonely
Bad				

From the words you circled, which three words best describe the discomfort you are feeling right now?

_____

_____

What day of the week do you have the worst discomfort? _____

What week of the month do you have the worst discomfort? _____

What season or month do you have the worst discomfort? _____

Have you ever noticed something that tells you that you are about to experience an episode of discomfort? (e.g., stiffness, particular thoughts or statements, physical sensations or irritability)

_____

_____

_____

How many hours a day do you have discomfort now? _____

How long does a single episode of discomfort last? _____

What do you call your discomfort? (For example, "headache", "joint pain", "stomach ache", "backache", etc.) Please list them in order of severity, #1 being the most severe pain.

Pain Problem #1: _____

Pain Problem #2: _____

Pain Problem #3: _____

On a scale of 0 – 10 (0 = no pain, 10= severe pain), how severe is your pain at the following times of the day?

6 AM _____	6 PM _____
9 AM _____	9 PM _____
Noon _____	12 AM _____
3 PM _____	3 AM _____

What is the worst time of the day? _____

What is the best time of the day? _____

Are you currently taking medication for discomfort? Yes No

If yes, please complete the following information.

Medication	Dose	# Times/Day	When	How effective 0=not effective10=very effective

What medications or other treatments have you tried in the past? On a scale of 0 – 10, (0 = not effective, 10 = very effective) how effective has each one been?

_____

_____

_____

_____

_____

What do you currently do, besides taking medication, to relieve your discomfort?

_____

_____

_____

Does your discomfort seem worse when you are:

	Yes	No		Yes	No
Tired			Angry		
Anxious			Busy		
Bored			Lonely		
Happy			Arguing		
Unhappy			upset		

Are there any other situations in which your discomfort is worse? If yes, what are they?

_____

_____

_____

Does your discomfort interfere with any of the following? Please circle the most correct number.

	Never	Rarely	Sometimes	Often	Always
Enjoying the family	1	2	3	4	5
Eating/appetite	1	2	3	4	5
Seeing friends	1	2	3	4	5
Sports	1	2	3	4	5
Sleeping	1	2	3	4	5
Watching TV	1	2	3	4	5
Reading	1	2	3	4	5
Schoolwork	1	2	3	4	5
Attending school	1	2	3	4	5
Going to the movies	1	2	3	4	5
Favorite activities	1	2	3	4	5
Un-liked activities	1	2	3	4	5

Comments:

_____

_____

_____

_____

Please rate how much discomfort you are having at the present time by placing a mark somewhere on the line.

Not hurting No discomfort No Pain	———————————————	Hurting a whole lot Very uncomfortable Severe Pain

Please rate how much discomfort you have on an average each day by placing a mark somewhere on the line.

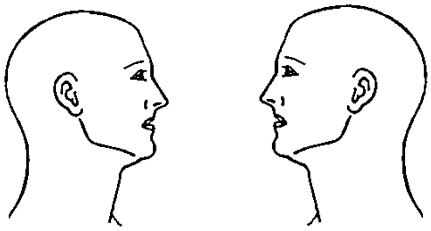
Not hurting No discomfort No Pain	———————————————	Hurting a whole lot Very uncomfortable Severe Pain

Please rate how severe the worst discomfort you had in the past week (7 days) by placing a mark somewhere on the line.

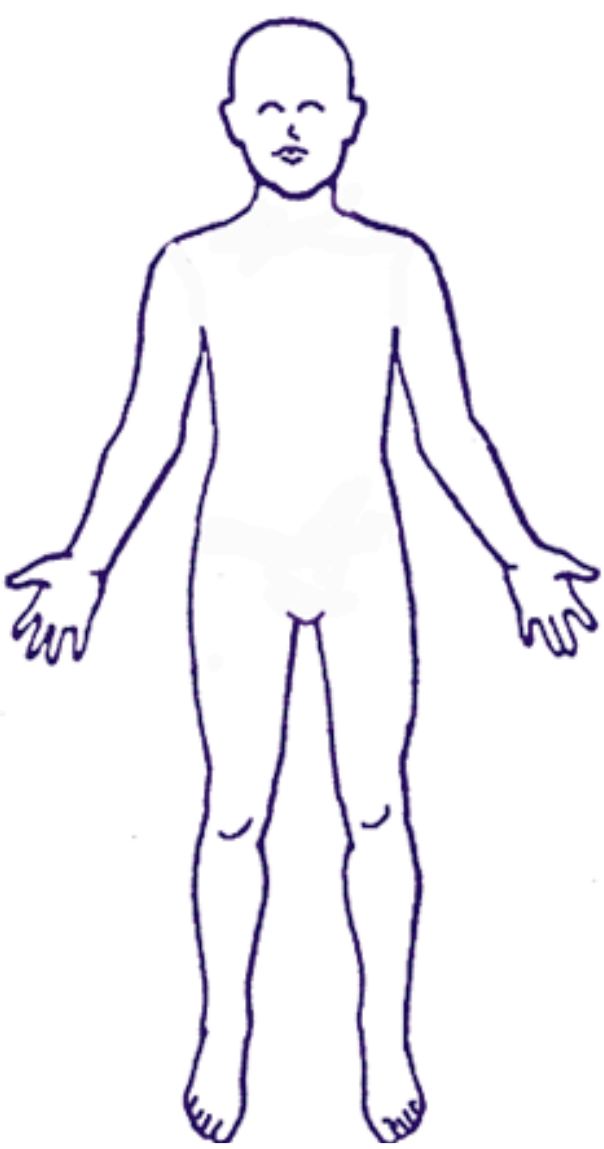
Not hurting No discomfort No Pain	———————————————	Hurting a whole lot Very uncomfortable Severe Pain

Please mark the exact place where you are having discomfort now. If there is more than one painful place, mark them “1”, “2”, “3”, etc., starting with the most painful place as “1”.

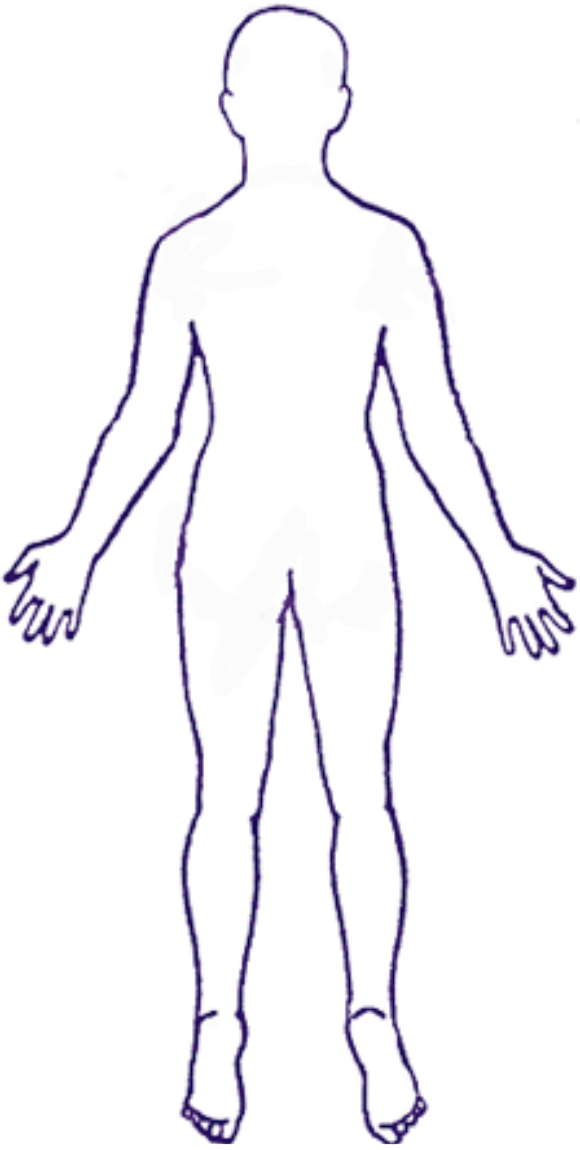
Right side of head



Left side of head



Front



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