PEDIATRIC PAIN QUESTIONNAIRE

Form P (Parent)

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The purpose of this questionnaire is to help us to obtain a comprehensive history of your child's 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: _____

Address: _____

_____

Phone number: _____

Relationship of person completing form to child: _____

Child Information:

Name: _____

Age: _____ Date of Birth: _____

Sex: _____

Grade in School: _____Name of School_____

Home Information: Please list the name, age and sex of all individuals living in the home.

Name	Age	Sex

Please list any health problems that your child has.

_____

_____

_____

If anyone else in the family has health problems, please list the person and the health problem. Example: son with asthma, husband with arthritis.

_____

_____

_____

Please list any severe and/or chronic family illnesses about which your child is aware.

Family member	Dates	Type of Illness	Outcome

Please list all severe and/or chronic pain problems experienced by other family members that your child has observed.

Family member	Dates	Type of Illness	Outcome

Are there currently any major life stresses affecting your family (e.g. divorce, separation, difficult financial burden, illness, deaths in the family)? If yes, please list.

_____

_____

_____

When did your child's 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 that time? Please explain.

_____

_____

Were any major changes occurring then in either your or your child's life? Please explain.

_____

_____

Is your child's current pain constant, or does it appear to come and go?

_____

_____

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

_____

_____

When your child has pain how do you respond? Please explain.

_____

_____

_____

If your child's pain were suddenly to disappear, how would it change his/her life?

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

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

Assuming that the pain continues, what kinds of things do you think your child should do now, which will help him/her later on?

Is there anything else you would like to tell us about your child's pain and the effect it has on your child, yourself or the family?

What words would you use to describe your child's pain?

Please circle any of the words listed below that you think describes your child's 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				

What day(s) of the week does your child have the worst pain? _____

What day(s) of the month does your child have the worst pain? _____

What season or month(s) does your child have the worst pain? _____

Have you ever noticed something that tells you that your child is about to experience a pain episode? (e.g., stiffness, particular thoughts or statements, physical sensations or irritability)

_____

_____

_____

How many hours a day does your child have pain now? _____

How long does a single pain episode last (minutes, hours)? _____

What do you label your child's pain as? (example: "head ache", "joint pain", "stomach ache", "back ache", 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 = none, 10= most severe), how would you rate your child's discomfort 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? _____

Is your child currently taking medication for pain? Yes No

If yes, please complete the following information.

Medication	Dose	# Times/Day	When	How effective 0=not effective 10=very effective

What medications or other treatments have been 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 giving medication, to help relieve your child's discomfort?

_____

_____

_____

Does your child's discomfort seem worse when s/he is:

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

Are there other situations in which your child's discomfort may worsen? Please describe?

_____

_____

_____

Does your child's 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 think your child is having <u>at the present time</u> 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 think your child has each day ,<u>on average</u>, by placing a mark somewhere on the line.

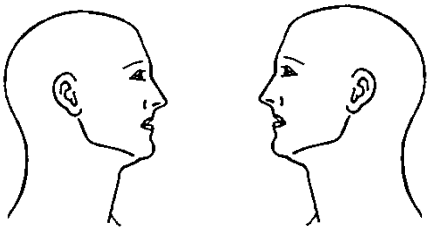
Not hurting No discomfort No Pain	———————————	Hurting a whole lot Very uncomfortable Severe Pain

Please rate how severe the <u>worst discomfort</u> your child had <u>in the past week</u> (7 days) by placing a mark somewhere on the line.

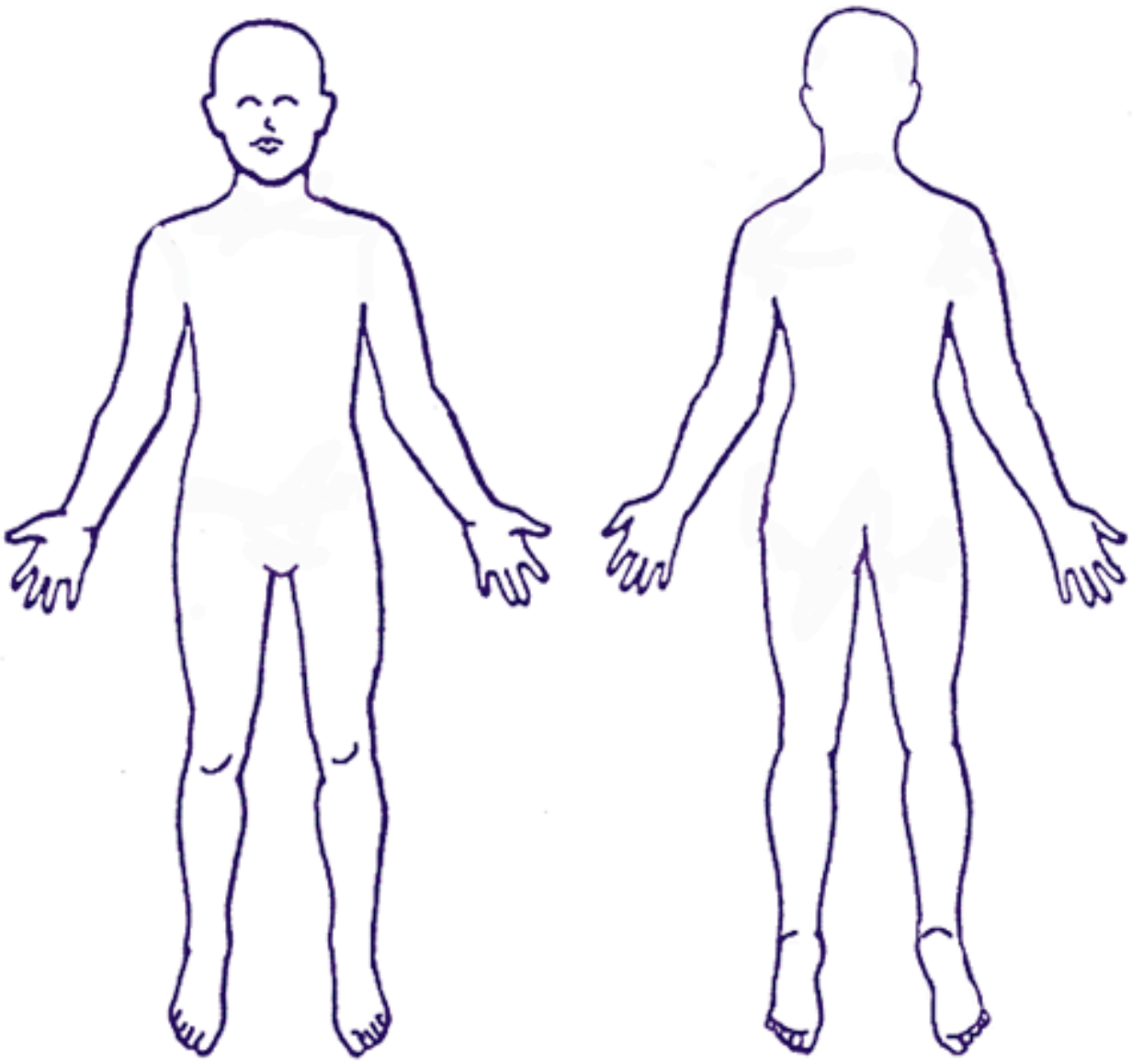
Not hurting No discomfort No Pain	———————————	Hurting a whole lot Very uncomfortable Severe Pain

Please mark the exact location where you think your child is 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



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