

## 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: \_\_\_\_\_

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.

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

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

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

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

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What words would you use to describe your pain?

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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 pain you are feeling right now?

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What day of the week do you have the worst pain? \_\_\_\_\_

What week of the month do you have the worst pain? \_\_\_\_\_

What season or month do you have the worst pain? \_\_\_\_\_

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

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How many hours a day do you have pain now? \_\_\_\_\_

How long does a single pain episode last? \_\_\_\_\_

What do you call your pain(s)? (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 pain? Yes No

If yes, please complete the following information.

Medication	Dose	# Times/Day	When	How effective 0=not effect 10=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 pain?

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Does your pain seem worse when you are:

	Yes	No		Yes	No
Tired	<hr/>		Angry	<hr/>	
Anxious			Busy		
Bored			Lonely		
Happy			Arguing		
Unhappy			upset		

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

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Does your pain 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:

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

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

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

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

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

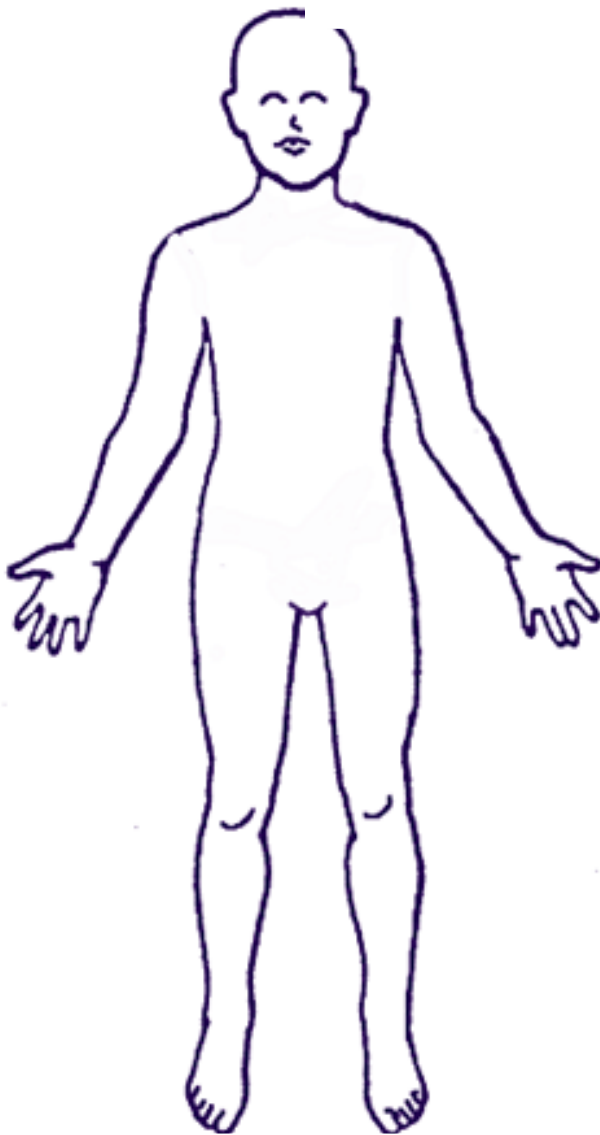
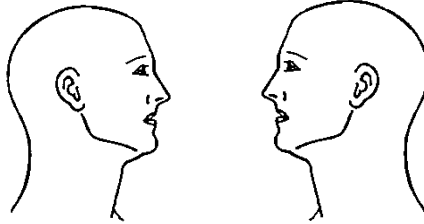
Not hurting \_\_\_\_\_ Hurting a whole lot  
No discomfort \_\_\_\_\_ Very uncomfortable  
No Pain \_\_\_\_\_ Severe Pain



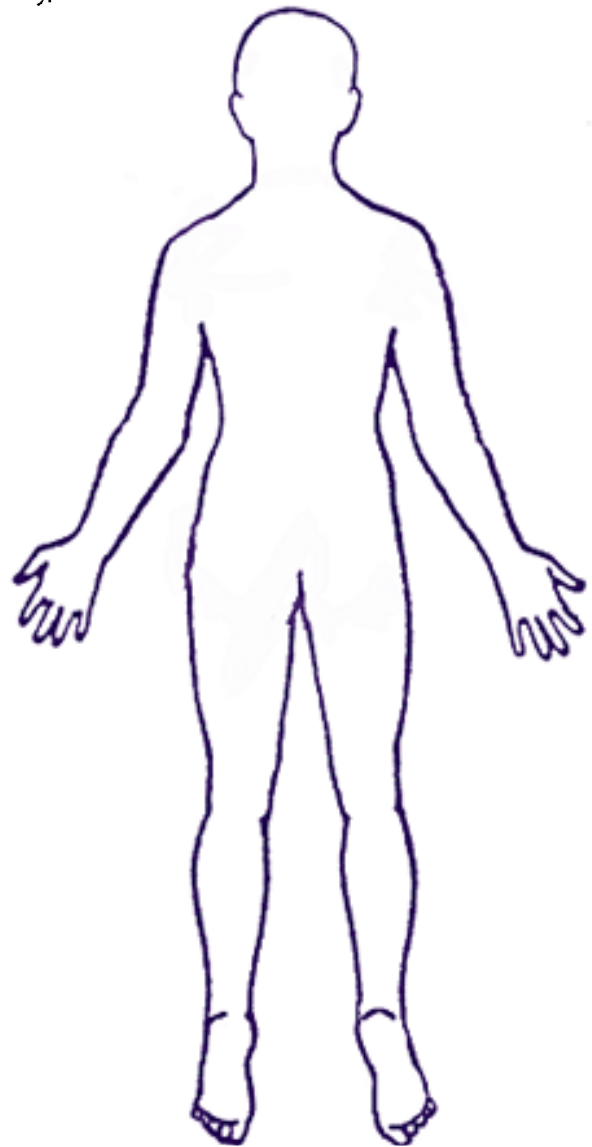
Please mark the exact place where you are having pain now. If there is more than one painful place, mark them "1", "2", "3", etc., starting with the most painful place as "1".

Right side of head

Left side of head



Front



Back