Calderdale and Huddersfield
NHS Foundation Trust

Pain Service

Pain Clinic Questionnaire

New Patients

Name	
Date of Birth	
MRN	
Date	

Please complete as much of this questionnaire as you can by answering the questions, ticking boxes, or circling where appropriate. If you need more space use additional pages.

Where does it hurt ?

Thinking about the pain that led to your referral, please draw on the picture to show where your worst pain(s) are. Feel free to write on the drawing if this would help using the symbols below to shade the areas.

Numbness	Pins and Needles	Ache	Pain
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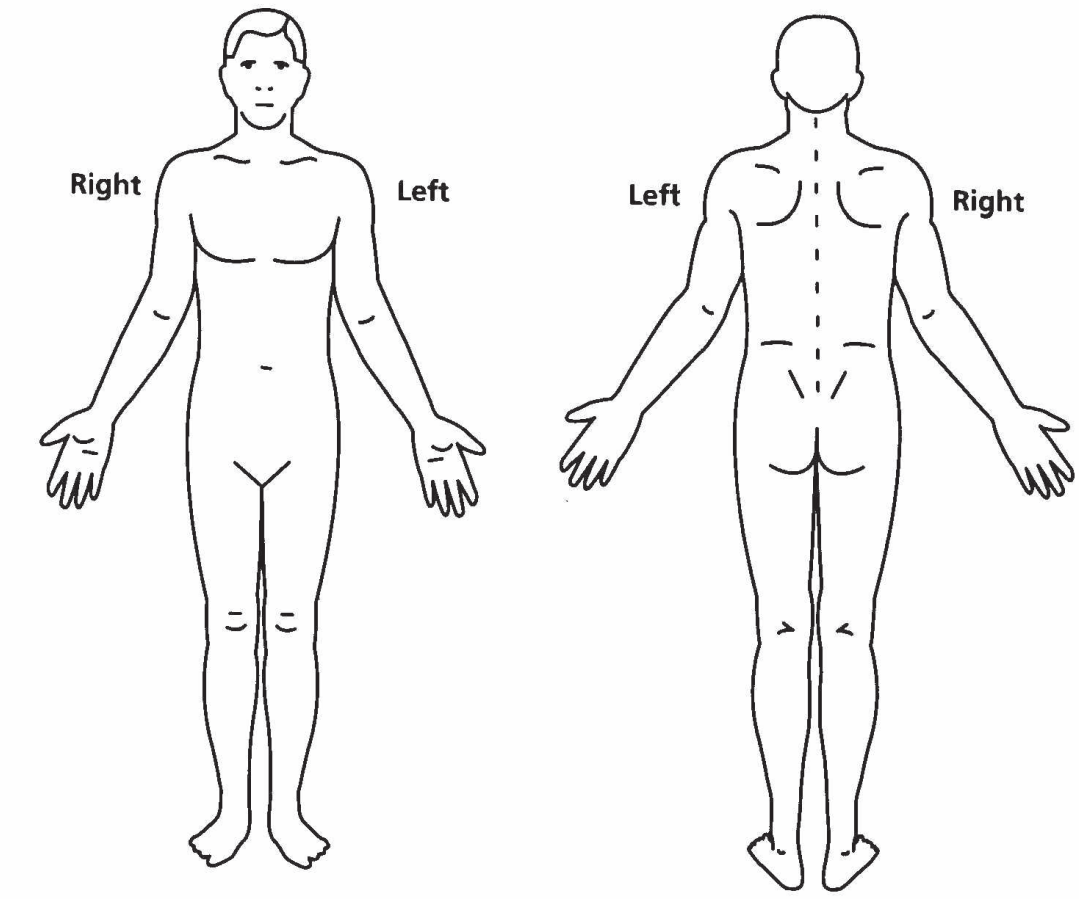


(Use additional paper if required)

When did your pain problem start?

How did your problem start?

What do you think is causing your pain?

What does your pain feel like? Use the words listed below to describe your pain. Tick as many as you need:

Dull ache	Stinging
Tingling	Shooting
Nagging	Stabbing
Gnawing	Sharp
Burning	Cramping
Other words:	

(Use additional paper if required)

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 ☐

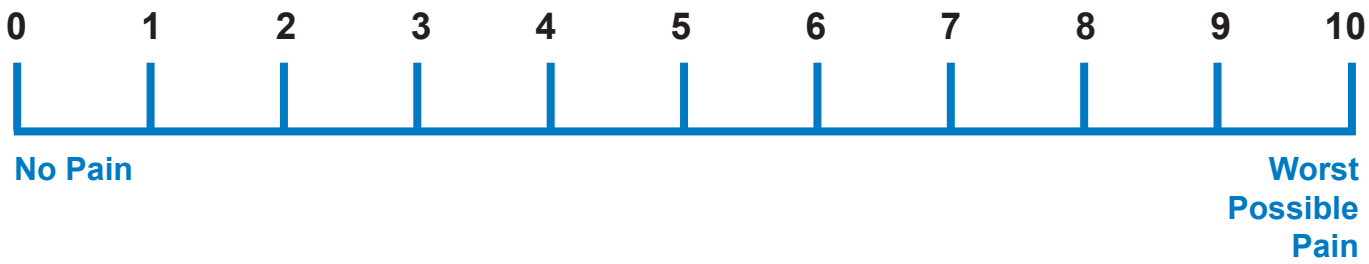
PAIN / DISCOMFORT

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 ☐

Please mark on the line below how your average pain feels



(Use additional paper if required)

Medication - kindly bring list of current medications

Previous medications you have tried and why they were stopped

What have you tried before for your current pain problem

Treatment	Having now	In the past	Effective (Yes / No)
Surgery			
Injections (e.g. nerve blocks, epidurals)			
Lidocaine Infusion			
Psychology/Counselling			
Physiotherapy			
TENS			
Acupuncture			
Osteopath/Chiropractor			
Heatpacks			
Anything else?			

Pain clinics rarely make people completely pain free.

What are your expectations of pain clinic?

What realistic goals do you want to achieve by managing your pain better?

Is there anything in particular you would like to ask us about your pain?

(Use additional paper if required)

If you have any comments about this leaflet or the service you have received you can contact :

Pain Clinic Reception

Telephone: 01422 224085

www.cht.nhs.uk

If you would like this information in another format or language contact the above.

Potřebujete-li tyto informace v jiném formátu nebo jazyce, obraťte se prosím na výše uvedené oddělení

Jeżeli są Państwo zainteresowani otrzymaniem tych informacji w innym formacie lub wersji językowej, prosimy skontaktować się z nami, korzystając z ww. danych kontaktowych

ਜੇ ਤੁਸੀਂ ਇਸ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਪ੍ਰਾਰੂਪ ਜਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਲੈਣਾ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਉੱਪਰੋਕਤ ਵਿਭਾਗ ਵਿੱਚ ਸਾਡੇ ਨਾਲ ਸੰਪਰਕ ਕਰੋ।

اگر آپ کو یہ معلومات کسی اور فارمیٹ یا زبان میں درکار ہوں، تو برائے مہربانی مندرجہ بالا شعبے میں ہم سے رابطہ کریں.

"إذا احتجت الحصول على هذه المعلومة بشكل مغاير أو مترجمة إلى لغة مختلفة فيرجى منك الاتصال بالقسم المذكور أعلاه"