INITIAL QUESTIONNAIRE

NAME _____

DATE _____

WPG
WESTERN **PAIN GROUP**

1. PAIN, ENJOYMENT, GENERAL ACTIVITY (PEG)

What number best describes your pain levels over the past week? (Where **0= No pain** and **10= Pain as bad as you can imagine**):

Lowest Pain:

No pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as you can imagine

Average Pain:

No pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as you can imagine

Worst Pain:

No pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as you can imagine

What number best describes how, during the past week, the pain has interfered with your enjoyment of life?

Doesn't Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes

What number best describes how, during the past week, the pain has interfered with your general activity?

Doesn't Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes

2. THE PATIENT SPECIFIED FUNCTIONAL OUTCOME SCALE — ACTIVITIES OF DAILY LIVING

List four activities that are most important to you that you really cannot, or have difficulty doing, because of your pain condition/s. Please also tick your relevent level of ability.

1. _____ Cannot do ☐ Can do somewhat ☐ Can do a lot ☐

2. _____ Cannot do ☐ Can do somewhat ☐ Can do a lot ☐

3. _____ Cannot do ☐ Can do somewhat ☐ Can do a lot ☐

4. _____ Cannot do ☐ Can do somewhat ☐ Can do a lot ☐

3. OTHER HEALTH CARE

List ALL medications you are currently taking (including supplements & vitamins):

Please list ALL allergies:

Tick any other treatment modalities you are currently having, or have tried previously:

- ☐ Physiotherapy
- ☐ Chiropractic
- ☐ Osteopathy
- ☐ Massage
- ☐ Exercises
- ☐ Natural Therapies
- ☐ Acupuncture
- ☐ Traditional Chinese Medicine
- ☐ Psychology
- ☐ Other

List any procedures you have previously had for this pain, e.g. injections, operations:

4. RETURN TO WORK

Are you currently working? Yes ☐ No ☐ **If yes, are you working full-time or part-time?** Full time ☐ Part Time ☐

If no, are you: Retired ☐ Seeking work ☐ Unable to work ☐

Please tick the words below that fit the description of your pain:

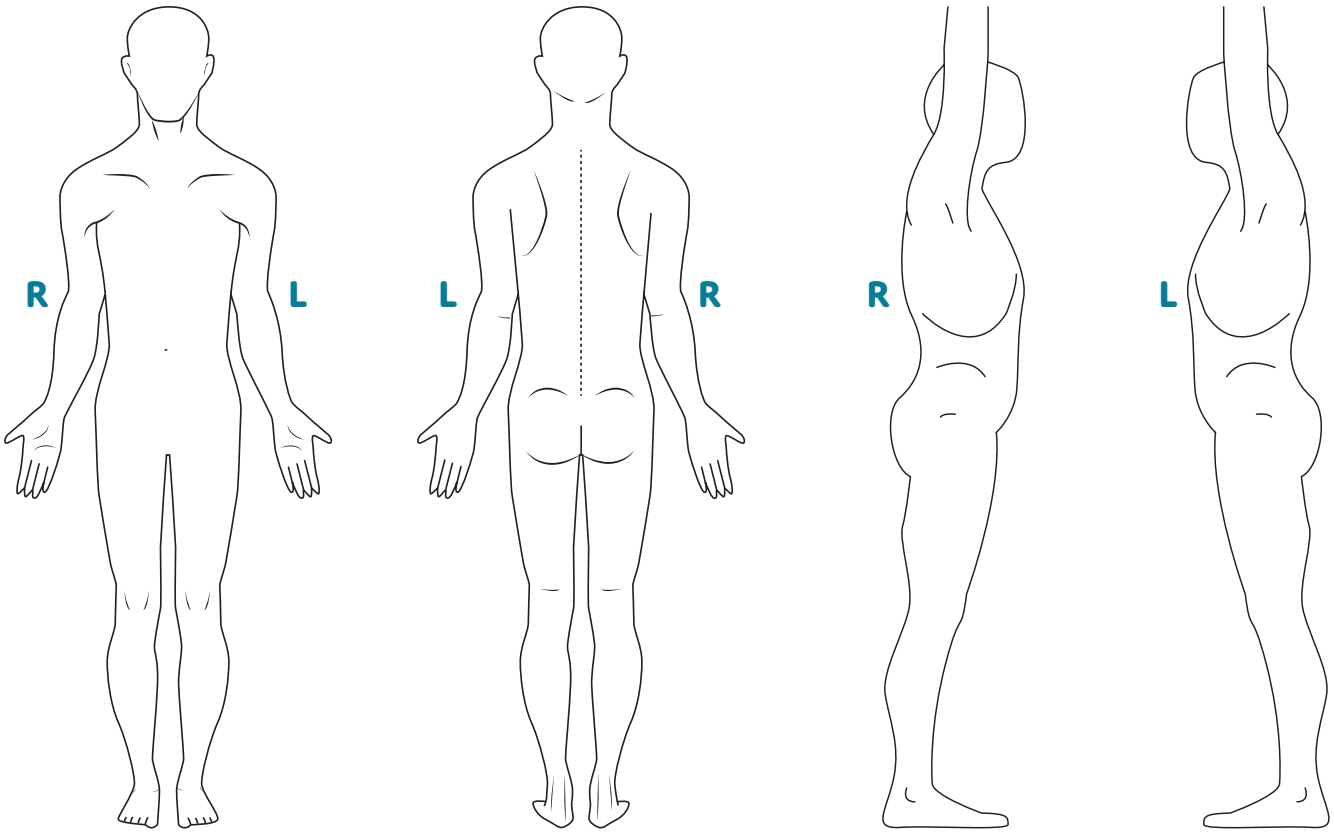
- ☐ Shooting
- ☐ Electric
- ☐ Stabbing
- ☐ Sharp
- ☐ Cramping
- ☐ Gnawing
- ☐ Hot/Burning
- ☐ Painful/Cold
- ☐ Throbbing
- ☐ Aching
- ☐ Pulling
- ☐ Dull
- ☐ Heavy
- ☐ Tender
- ☐ Tight
- ☐ Splitting
- ☐ Tiring/Exhausting
- ☐ Sickening
- ☐ Fearful
- ☐ Punishing
- ☐ Cruel
- ☐ Terrifying
- ☐ Nauseating
- ☐ Agonising

Does your pain interfere with your sleep? Yes ☐ No ☐

If yes, how many nights on average per week?

5. MARK ON THE DIAGRAM BELOW THE AREAS WHERE YOU FEEL PAIN

X = pain **O** = abnormal sensation, e.g. numbness, tingling, pins and needles.



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

I can enjoy day to day life, despite the pain:

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

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

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

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

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

I can cope with my pain in most situations:

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

I can do some form of work, despite the pain ('work' includes housework, paid & unpaid work):

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

I can still enjoy hobbies or leisure activities, despite the pain:

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

I can cope with my pain without any medication:

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

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

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

I can live a normal lifestyle, despite the pain:

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

I can gradually become more active, despite the pain:

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

7. PLEASE PLACE A TICK IN THE BOX THAT BEST APPLIES TO YOU IN THE PAST FOUR WEEKS

	Never	Not very often	Occasionally	Often	Always
1. How often did you feel tired for no apparant reason?					
2. How often did you feel nervous					
3. How often did you feel so nervous that nothing could calm you down? (Please skip to question 7 if your answer is 'Never')					
4. How often did you feel hopeless?					
5. How often did you feel restless or fidgety?					
6. How often did you feel so restless you couldn't sit still?					
7. How often did you feel depressed?					
8. How often did you feel that everything was an effort?					
9. How often did you feel so sad that nothing could cheer you up?					
10. How often did you feel worthless?					

8. MOM DISABILITY SCALE

During the past week how difficult was it (or would it have been) for you to do the following activities.

Circle the best option for each question.

	No trouble	A bit difficult	Moderately difficult	Very difficult	Can't do at all	N/A
Your normal work (including both work outside the home and housework)	0	1	2	3	4	-
Your normal social activities	0	1	2	3	4	-
Your usual sport and recreation	0	1	2	3	4	-
Getting dressed, bathing and personal hygiene	0	1	2	3	4	-
Usual sexual activity	0	1	2	3	4	-
Travelling in a car	0	1	2	3	4	-
Travelling by public transport	0	1	2	3	4	-
Walking 100 metres	0	1	2	3	4	-
Walking on flat ground for more than one kilometre	0	1	2	3	4	-
Walking on uneven ground	0	1	2	3	4	-
Walking up and down stairs	0	1	2	3	4	-
Kneeling and squatting	0	1	2	3	4	-
Rising from sitting	0	1	2	3	4	-
Running	0	1	2	3	4	-
Bending forwards or stooping	0	1	2	3	4	-
Lifting & carrying 10kg (eg. two large bags of potatoes)	0	1	2	3	4	-
Sitting at a desk	0	1	2	3	4	-
Looking up and down	0	1	2	3	4	-
Turning your head to look over your shoulder	0	1	2	3	4	-
Reaching overhead to a high shelf	0	1	2	3	4	-
Writing at a desk or typing at a keyboard	0	1	2	3	4	-
Lifting or carrying groceries	0	1	2	3	4	-
Reaching up behind your back	0	1	2	3	4	-
Throwing a ball	0	1	2	3	4	-
Opening tight jars or bottle tops	0	1	2	3	4	-