Pain Treatment Planning Questionnaire

We want to better understand your pain, both pain related to your bleeding disorder or other pain. We will use your answers to help plan treatment that will reduce pain and help you do the things you want to do. Please answer questions on both sides of the page.

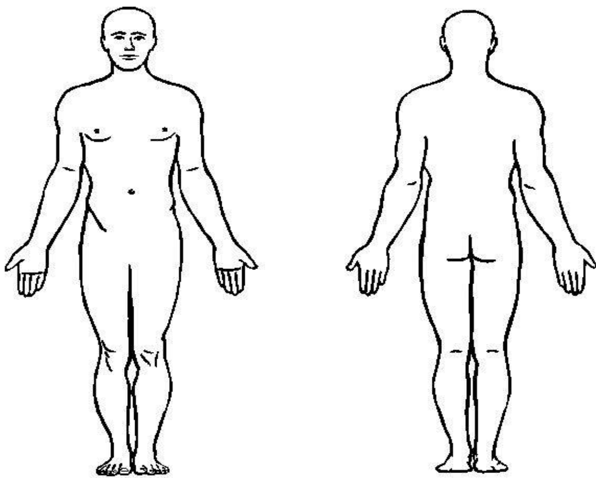
ADDRESSOGRAPH

Date: ___________________________

1. Indicate on the diagram below where you felt bodily pain from any cause in the past 30 days.

Circle any areas where you have had pain or discomfort.

Mark with X's any areas where you have had numbness, tingling or pins and needles sensations.



2. Please answer the following questions about how strong or intense your pain has been the past 30 days. When answering, think about the area that is your main concern. (Circle the number)

a) How would you rate your pain right now?

0 No pain 1 2 3 4 5 6 7 8 9 10 Most pain possible

b) How would you rate the lowest level of pain you have had this past 30 days?

0 No pain 1 2 3 4 5 6 7 8 9 10 Most pain possible

c) How would you rate the most/worst pain you have had this past 30 days?

0 No pain 1 2 3 4 5 6 7 8 9 10 Most pain possible

d) **How would you rate your usual level of pain on a typical day this past 30 days?**

0 No pain 1 2 3 4 5 6 7 8 9 10 Most pain possible

e) **How often do you usually have pain? (Circle word)**

Never or rarely | About once a month | About once a week | A few times a week | Daily

3. The following words are sometimes used to describe how pain feels. Circle ALL the words that describe the pain you felt in the past 30 days (if applicable).

Throbbing	Aching	Sharp	Tender	Pressure	Tiring
Nagging	Burning	Sensitive to touch	Electric shocks	Tingling	Prickling
Bursting	Miserable	Shooting	Constant	Comes and goes	

Please list any other words you use to describe your pain.

____

4. a) What made your pain less noticeable in the past 30 days (e.g. ice, activities, positions)?

____

b) What made your pain worse in the past 30 days (e.g. activities, positions)?

____

5. a) Is there a time of day that your pain is usually more noticeable (worse)? (Circle) Yes / No

b) If yes, what time of day is your pain worse?

____

6. a) In the past 30 days, did you limit any of your activities because of pain (e.g. work/school, socialize, sex)? Yes / No

b) If yes, how often and what activities did you limit?

____

7. a) In the past 30 days, did pain affect your mood? Yes / No

b) If yes, how often and what was the effect?

____

8. Overall, how satisfied are you with your current pain management?

Very unsatisfied | A little unsatisfied | Neither satisfied nor unsatisfied | A little satisfied | Very satisfied

9. Treatment Goals: How can we help you?

____
____
____
____
____

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Please complete questions on other side.

Pain Treatment Planning Questionnaire

Patient Name:___________________________
HSN:____________________________________

What have you used to help with your pain **since your last clinic visit**. Your treatment team will use your answers to discuss pain management options with you.

INSTRUCTIONS: Mark the box with a ✓ beside any treatments you have used since your last bleeding disorders clinic visit.

(NOTE: not all of these treatments are recommended. Talk to your health care provider about what is right for you)

10. PHARMACEUTICAL/MEDICAL	
Over the counter pain medicine	
Acetaminophen (e.g. Tylenol)	
NSAID anti-inflammatory (e.g. Aspirin, ibuprophen, Motrin, Advil, Aleve)	
Topical ointments (e.g. Voltaren)	
Sleep aids (e.g. TylenolPM, Benadryl, gravol)	
Prescription pain medicine	
Steroid pills or needle (e.g. prednisone)	
Opioid (e.g. Tylenol#3, Morphine, Dilaudid)	
NSAID anti-inflammatory (e.g. Arthrotec, Celebrex)	
Relaxant (e.g. Flexeril, Valium, Ativan)	
Nerve pain medicine (e.g. gabapentin, pregabalin)	
Antidepressant (e.g. amitriptyline, nortriptyline, Cymbalta)	
Medical marijuana	
Other:	

11. Overall, how well do you feel you are able to manage your pain with medication/medical treatments? (Circle number)

N/A 0 (Not at all well) 1 2 3 4 5 6 7 8 9 10 (Managing very well)

Physician Specialists (circle if you have had a consultation with the following): Pain specialist, anesthesiologist, physiatrist, rheumatologist, other (please list)

Please provide a list of any naturopathic, vitamin, herbal, or homeopathic products you take.

12. PSYCHOLOGICAL	
Pain self-management training course	
Distraction (e.g. watching TV)	
Relaxation (e.g. deep breathing, imagery)	
Relationship counselling	
Spirituality (e.g. prayer, smudging, meditation)	
Treatment with a psychologist or social worker (e.g. cognitive behavioral therapy, hypnosis)	
Other:	

13. Overall, how well do you feel you are able to manage your pain with psychological treatments? (Circle number)

N/A 0 (Not at all well) 1 2 3 4 5 6 7 8 9 10 (Managing very well)

14. PREVENTION	
Preventative factor treatment (prophylactic factor)	
Regular clinic visits	
Prevent needle pain (e.g. distraction, topical pain relievers, deep breathing)	
Mobility aides (e.g. cane, walker, wheelchair)	
Splints, braces, orthotics	
Pacing: balancing activity and rest throughout day	
Ergonomic set up of work or home (e.g. computer station set up, anti-fatigue mat)	
Avoid painful activities	
Work/career choices or modifications	
Other:	

15. Overall, how well do you feel you are able to manage your pain with preventative treatments? (Circle number)

N/A 0 (Not at all well) 1 2 3 4 5 6 7 8 9 10 (Managing very well)

16. PHYSICAL	
Thermal agents	
Heat (e.g. hot packs, hot tub)	
Cold (e.g. ice packs, cold baths)	
Joint or muscle mobilizations (e.g. physical therapy, chiropractic, massage)	
Acupuncture	
Electrical agents (e.g. TENS)	
Other:	

17. Overall, how well do you feel you are able to manage your pain with physical treatments? (Circle number)

N/A 0 (Not at all well) 1 2 3 4 5 6 7 8 9 10 (Managing very well)

EXERCISE

18. Stretching/range of motion (e.g. stretches, yoga). How often do you do stretching exercises? ______________times/week

19. Strengthening (e.g. lifting weights). How often do you do strengthening exercises? _______________ times/week

20. Cardiovascular (e.g. walking, running, swimming, dancing). How often do you do cardiovascular/aerobic fitness exercises? _________times/week for ___________ minutes per session.

____

Initial when reviewed: ____________ Hematologist ________ RN ________ PT ________ SW ________ Other

The End—Thank You.