

Patient name: _____ DOB: _____ Date: _____

Questionnaire for Low Back, Hip & Pelvic Pain

Please describe your pain problem(s) _____

Is there an event that you associate with the onset of your pain? Yes No

If so, what? _____

How long have you had pain? _____ years _____ months

What have you been told is causing your pain? _____

What do you think is causing your pain? _____

Has the pain spread from its original problem? Yes No

Social History

The Adverse Childhood Experience (ACE) study (1997) demonstrated with > 17,000 participants that traumatic experiences during childhood have a direct impact on the health of adults, especially if they have not been given the opportunity to talk about these events in a safe and empathetic environment. In that regard, your social history is very important and confidential. These questions apply to events that happened in your childhood.

Where were you born? _____

How many siblings do you have? _____

How would you describe your childhood? Average / Happy / Sad / Other:

Were you physically/emotionally abused as a child? Yes No

Have you been touched sexually when you did not want it? Yes No

Have you ever had sex against your will? Yes No

Has anyone in your family been killed? Yes No

Has anyone in your family had a nervous breakdown? Yes No

Has anyone in your family committed suicide? Yes No

Has anyone in your family been a drug abuse user or alcoholic? Yes No

Do you abuse drugs or alcohol? Yes No

Have you ever fought in a war? Yes No

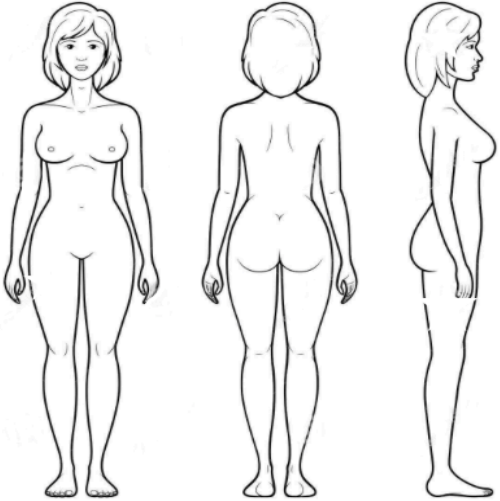

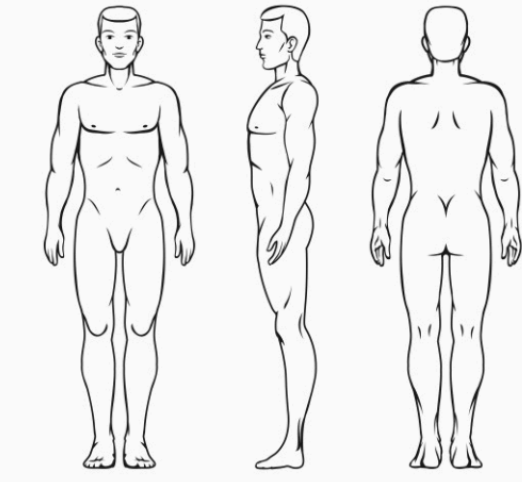
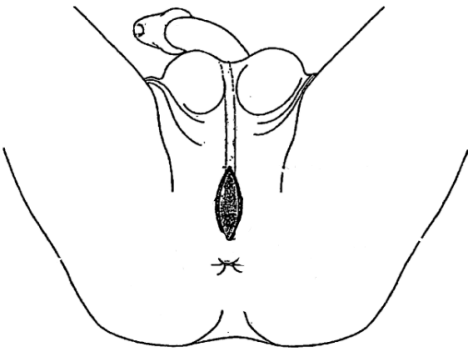
Have you ever lived in a war zone? Yes No

Are you: Married Widowed Separated Single Remarried
 Divorced Committed relationship

Patient name: _____ DOB: _____ Date: _____

Who lives in your home? _____
Who are the people you talk to when you are in pain? _____
What do you do to cope with stress? _____
How does your partner cope with your pain/stress? _____
How does your pain affect your family? _____
What type of work are you trained for? _____
What type of work are you doing? _____
Do you like your job? _____
Have you ever been for counseling? _____

Please mark the appropriate pain diagrams – indicate where your symptoms are and describe as appropriate

Patient name: _____ DOB: _____ Date: _____

Are you physically intimate with your partner without penetration? No Sometimes Yes

Do you have pain with penetration? Yes Sometimes No

If yes, where and when _____

Are you able to orgasm? No Sometimes Yes

Do you have pain with orgasm? Yes Sometimes No

Do you have pain after orgasm? Yes Sometimes No

If you are unable to have intercourse with penetration, can you orgasm with manual stimulation? No Sometimes Yes

Does your partner have sexual dysfunction? Yes Sometimes No

If yes, what type? _____

How is your libido? Non-existent Decreased Increased Normal

Do you regularly self-pleasure? No Sometimes Yes

Do you use lubrication? No Yes

If yes, what type _____

Have you ever talked to a professional about sexual function? No Yes

What makes your pain worse?

Intercourse Orgasm Stress Full meal Bowel movement

Full bladder Urination Standing Walking Exercise

Time of day Sitting Contact with clothing Coughing/sneezing Weather

Sexual activity Use of tampon Not related to anything

Other: _____

What helps soothe your pain?

Meditation Relaxation Lying down Music Massage

Ice Hot bath Heating pad Pain medication Laxatives/enema

Injection TENS unit Bowel movement Emptying bladder Nothing

Other: _____

Have you been diagnosed by a doctor with any of the following conditions?

			Date of Diagnosis
Restless leg syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Chronic fatigue syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Fibromyalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Temporomandibular joint disorder (TMJ)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Migraine or tension headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Irritable bowel syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Multiple chemical sensitivities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Neck injury (including whiplash)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Anxiety or panic attacks	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

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What physician's or health care providers have you seen for these problems	
Physician/provider	Treatment provided

Please list the medications you are currently taking (including vitamins and supplements)				
Medication/dose	Provider			
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Currently taking
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Currently taking

Have you taken any of the following supplements for this problem?

	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Dosage
Vitamin D	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Magnesium	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Omega 3	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Cranberry juice/extract	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

Sleep Hygiene

- Does it usually take you longer than 30 minutes to fall asleep? Yes No
- Do you wake up more than twice a night? Yes No
- Do you regularly drink coffee, tea, caffeinated pop or alcoholic drinks? Yes No
- Do you feel that you are currently under significant stress? Yes No
- Do you feel stress/anxiety contributes to your sleeping difficulties? Yes No
- Do you feel that you are sensitive to noises and/or that noises wake you up? Yes No
- Do you have sources of light in your bedroom at night? Yes No
- Does your sleeping partner keep you awake? Yes No

Patient name: _____ DOB: _____ Date: _____

- Do you feel that the air in your bedroom is too hot, cold or not fresh enough? Yes No
- Do you feel that your mattress or your pillow is uncomfortable or > 10 years old? Yes No
- Do you sleep on your stomach? Yes No
- Do you have "creeping, crawling or tingling" feelings in your legs? Yes No
- Do you think you snore loudly, gasp or stop breathing during sleep? Yes No
- Do you take narcotics for pain? Yes No

The Fremantle _____ Awareness Questionnaire

This questionnaire has been tested on those people who have back pain. It measures how people with low back pain are aware of how their low back moves and functions. The researchers have agreed that therapists can use this questionnaire to also measure how people with pain are aware of their painful parts and how they move them.

Therefore, please fill in the blanks on this questionnaire with your painful part (the most painful one if you have multiple painful areas), and then answer the questions to the best of your ability. Using the following scale, please indicate the degree to which your _____ feels this way when you are experiencing _____ pain

	Never	Rarely	Occasionally	Often	Always
1. My _____ feels as though it is not part of the rest of my body	0	1	2	3	4
2. I need to focus all my attention on my _____ to make it move the way I want it to	0	1	2	3	4
3. I feel as if my _____ sometimes moves involuntarily, without my control	0	1	2	3	4
4. When performing everyday tasks, I don't know how my _____ is moving	0	1	2	3	4
5. When performing everyday tasks, I am not sure exactly what position my _____ is in	0	1	2	3	4
6. I can't perceive the exact outline of my _____	0	1	2	3	4
7. My _____ feels like it is enlarged (swollen)	0	1	2	3	4
8. My _____ feels like it has shrunk	0	1	2	3	4
9. My _____ feels lopsided (asymmetrical)	0	1	2	3	4

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Central Sensitization Inventory: Part A

Please circle the best response to the right of each statement

I feel un-refreshed when I wake up in the morning.	Never	Rarely	Sometimes	Often	Always
My muscles feel stiff and achy.	Never	Rarely	Sometimes	Often	Always
I have anxiety attacks.	Never	Rarely	Sometimes	Often	Always
I grind or clench my teeth.	Never	Rarely	Sometimes	Often	Always
I have problems with diarrhea and/or constipation.	Never	Rarely	Sometimes	Often	Always
I need help in performing my daily activities.	Never	Rarely	Sometimes	Often	Always
I am sensitive to bright lights.	Never	Rarely	Sometimes	Often	Always
I get tired very easily when I am physically active.	Never	Rarely	Sometimes	Often	Always
I feel pain all over my body.	Never	Rarely	Sometimes	Often	Always
I have headaches.	Never	Rarely	Sometimes	Often	Always
I feel discomfort in my bladder and/or burning when I urinate.	Never	Rarely	Sometimes	Often	Always
I do not sleep well.	Never	Rarely	Sometimes	Often	Always
I have difficulty concentrating.	Never	Rarely	Sometimes	Often	Always
I have skin problems such as dryness, itchiness or rashes.	Never	Rarely	Sometimes	Often	Always
Stress makes my physical symptoms get worse.	Never	Rarely	Sometimes	Often	Always
I feel sad or depressed.	Never	Rarely	Sometimes	Often	Always
I have low energy.	Never	Rarely	Sometimes	Often	Always
I have muscle tension in my neck and shoulders.	Never	Rarely	Sometimes	Often	Always
I have pain in my jaw.	Never	Rarely	Sometimes	Often	Always
Certain smells, such as perfumes, make me feel dizzy and nauseated.	Never	Rarely	Sometimes	Often	Always
I have to urinate frequently.	Never	Rarely	Sometimes	Often	Always
My legs feel uncomfortable and restless when I am trying to go to sleep at night.	Never	Rarely	Sometimes	Often	Always
I have difficulty remembering things.	Never	Rarely	Sometimes	Often	Always
I suffered trauma as a child.	Never	Rarely	Sometimes	Often	Always
I have pain in my pelvic area.	Never	Rarely	Sometimes	Often	Always

TOTAL _____

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Central Sensitization Inventory: Part B

Have you been diagnosed by a doctor with any of the following disorders?

Please check the box to the right for each diagnosis and write the year of diagnosis

	No	Yes	Diagnosed
1. Restless leg syndrome			
2. Chronic fatigue syndrome			
3. Fibromyalgia			
4. Temporomandibular joint disorder (TMJ)			
5. Irritable bowel syndrome			
6. Multiple chemical sensitivities			
7. Neck injury (including whiplash)			
9. Anxiety or panic attacks			
10. Depression			

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PCS Questionnaire

(Reference: Quartana et al. 2009)

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are 13 statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you experience pain.

0 = not at all 1 = to a slight degree 2 = to a moderate degree 3 = to a great degree 4 = all the time

When I'm in pain.....

- (H) _____ I worry all the time about whether the pain will end
- (H) _____ I feel I can't go on
- (H) _____ It's terrible and I think it's never going to get any better
- (H) _____ It's awful and I feel that it overwhelms me
- (H) _____ I feel I can't stand it anymore
- (M) _____ I become afraid that the pain will get worse
- (M) _____ I keep thinking of other painful events
- (R) _____ I anxiously want the pain to go away
- (R) _____ I can't seem to keep it out of my mind
- (R) _____ I keep thinking about how much it hurts
- (R) _____ I keep thinking about how badly I want the pain to stop
- (H) _____ There's nothing I can do to reduce the intensity of my pain
- (M) _____ I wonder whether something serious will happen

TOTAL: _____

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PANAS

(Reference: Watson, D., Clark, L. A., & Tellegan, A. 1988)

This scale consists of a number of words that describe different feelings and emotions. Read each item and then list the number from the scale below next to each word. Indicate to what extent you feel this way right now, that is, at the present moment *OR* indicate the extent you have felt this way over the past week. Please circle if you used this measure for the present moment or over the past week.

1	2	3	4	5
Very slightly or not at all	A little	Moderately	Quite a bit	Extremely

- | | |
|----------------------|---------------------|
| 1. ____ Interested | 11. ____ Irritable |
| 2. ____ Distressed | 12. ____ Alert |
| 3. ____ Excited | 13. ____ Ashamed |
| 4. ____ Upset | 14. ____ Inspired |
| 5. ____ Strong | 15. ____ Nervous |
| 6. ____ Guilty | 16. ____ Determined |
| 7. ____ Scared | 17. ____ Attentive |
| 8. ____ Hostile | 18. ____ Jittery |
| 9. ____ Enthusiastic | 19. ____ Active |
| 10. ____ Proud | 20. ____ Afraid |

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TSK

(Reference: the original TSK9 is copied without restriction from the Work Cover Victoria website)

For Office use only: Rvs 4, 8, 12, 16 Score: _____

Please read each of the following statements and circle the number that best represents your feelings.

1 = Strongly disagree 2 = Somewhat Disagree 3 = Somewhat Agree 4 = Strongly Agree

- | | | | | |
|--|---|---|---|---|
| (S) I'm afraid I might injure myself if I exercise | 1 | 2 | 3 | 4 |
| (A) If I were to try to overcome it, my pain would increase | 1 | 2 | 3 | 4 |
| (S) My body is telling me that I have something dangerously wrong | 1 | 2 | 3 | 4 |
| (A) My pain would probably be relieved if I were to exercise | 1 | 2 | 3 | 4 |
| (S) People aren't taking my medical condition seriously enough | 1 | 2 | 3 | 4 |
| (S) My accident has put my body at risk for the rest of my life | 1 | 2 | 3 | 4 |
| (S) Pain always means that I have injured my body | 1 | 2 | 3 | 4 |
| (A) Just because something aggravates my body does not mean it is dangerous | 1 | 2 | 3 | 4 |
| (A) I am afraid that I might injure myself accidentally | 1 | 2 | 3 | 4 |
| (A) Simply being careful that I do not make any unnecessary movements is the safest thing I can do to prevent my pain from worsening | 1 | 2 | 3 | 4 |
| (S) I wouldn't have this much pain if there weren't something potentially dangerous going on in my body | 1 | 2 | 3 | 4 |
| (A) Although my condition is painful, I would be better off if I were physically active | 1 | 2 | 3 | 4 |
| (A) Pain lets me know when to stop exercising so that I don't injury myself | 1 | 2 | 3 | 4 |
| (A) It's really not safe for a person with a condition like mine to be physically active | 1 | 2 | 3 | 4 |
| (A) I can't do all the things normal people do because it's too easy for me to get injured | 1 | 2 | 3 | 4 |
| (A) Even though something is causing me a lot of pain, I don't think it's actually dangerous | 1 | 2 | 3 | 4 |
| (A) No one should have to exercise when he/she is in pain | 1 | 2 | 3 | 4 |

TOTALS

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Patient name: _____ DOB: _____ Date: _____

Pain Self-Efficacy Questionnaire PSEQ-2

(Michael. K Nicholas, PhD, Brian E. McGuire, PhD, and Ali Asghari, PhD)

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.**

	0	1	2	3	4	5	6
1. I can do some form of work, despite the pain (“work” includes housework and paid and unpaid work)	Not at all confident						Completely confident
2. I can live a normal lifestyle, despite the pain	Not at all confident						Completely confident