UMassMemorial

DEPARTMENT OF FAMILY MEDICINE
AND COMMUNITY HEALTH

Patient Registration Stamp

PATIENT BASELINE ASSESSMENT PACKET

FOR CHRONIC PAIN EVALUATION

Department of Family Medicine and Community Health

Your Name: _____ Date: _____

All patients who need help to manage chronic pain are being asked to complete some self-assessment materials.

Filling out these materials is entirely voluntary. But they will be very useful for your primary care provider to help make the best care decisions with you about your pain.

They will increase the quality of care we give our patients experiencing pain.

Please fill out the questionnaires as carefully as possible. Your Primary Care Clinician will review them with you as part of your visit once a year.

Some of the questions will be repeated at each visit, such as your current pain and functional levels.

If you have any questions, please feel free to ask the nurses or office staff while your complete the forms.

Patient Name:_____DOB:_____MR#_____

BRIEF PAIN INVENTORY (SHORT FORM)© 1991

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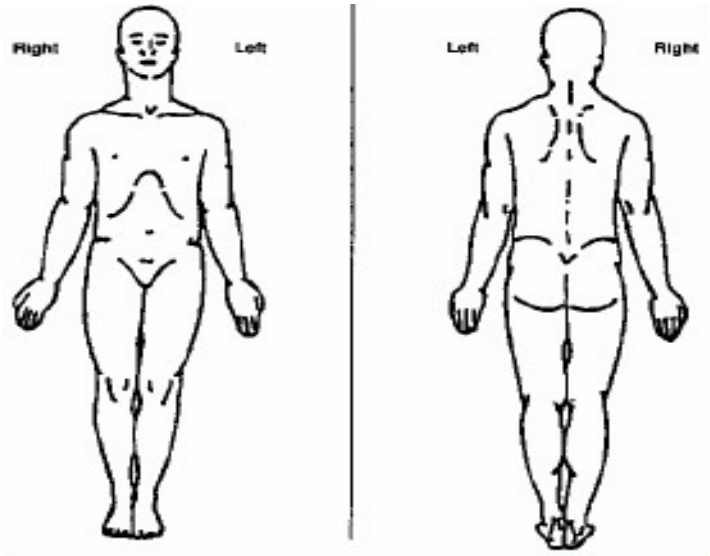
1. Throughout our lives, most of us have had pan from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these every day kinds of pain today?

☐ YES ☐ NO

2. On the diagram, shade in the areas where you feel pain. Put an "X" on the area that hurts the most.

FRONT BACK



3. Please rate your pain by marking the box beside the number that best describes your pain at its **worst** in the last 24 hours.

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No Pain — Pain As Bad As You Can Imagine

4. Please rate your pain by marking the box beside the number that best describes your pain on the **average**.

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No Pain — Pain As Bad As You Can Imagine

5. Please rate your pain by marking the box beside the number that tells how much pain you have **right now**.

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No Pain — Pain As Bad As You Can Imagine

6. Please rate your pain by marking the box beside the number that best describes your pain at its **least** in the last 24 hours.

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No Pain — Pain As Bad As You Can Imagine

Patient Name:_____DOB:_____MR#_____

7. In the last 24 hours, how much relief have pain treatments or medications provided? Please mark the box below the percentage that most shows how much **relief** you have received?

❑ 0% ❑ 10% ❑ 20% ❑ 30% ❑ 40% ❑ 50% ❑ 60% ❑ 70% ❑ 80%❑ 90% ❑ 100%

No Relief _____ Complete Relief

8. Mark the box beside the number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Does Not Interfere _____ Completely Interferes

B. Mood

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Does Not Interfere _____ Completely Interferes

C. Walking ability

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Does Not Interfere _____ Completely Interferes

D. Normal work (includes both work outside the home and housework)

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Does Not Interfere _____ Completely Interferes

E. Relations with other people

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Does Not Interfere _____ Completely Interferes

F. Sleep

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Does Not Interfere _____ Completely Interferes

OFFICE USE ONLY:

MEAN of items #3, 4, 5= _____ X 100=_____ BPI TOTAL PAIN SCORE

MEAN of #8 A, D, E= _____ X100=_____BPI TOTAL FUNCTIONAL SCORE

Patient Name:_____DOB:_____MR#_____

PATIENT QUESTIONNAIRE - PHQ-9

Nine Symptom Checklist

1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

		Not at all	Several days	More than half the days	Nearly every day
		0	**1**	**2**	**3**
a.	**Little interest or pleasure in doing things**	☐	☐	☐	☐
b.	**Feeling down, depressed, or hopeless**	☐	☐	☐	☐
c.	Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d.	Feeling tired or having little energy	☐	☐	☐	☐
e.	Poor appetite or overeating	☐	☐	☐	☐
f.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g.	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h.	Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i.	Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

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2. In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?

   ☐ Yes ☐ No

3. If you checked off <u>any</u> problem on this questionnaire so far, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult
☐	☐	☐	☐

FOR OFFICE USE ONLY: _____Total Score

Patient Name:_____DOB:_____MR#_____

ALCOHOL USE (AUDIT)—Please circle your answer to each question.					
How often do you have a drink containing alcohol?	(0) Never	(1) Monthly	(2) 2-4 times a month	(3) 2-3 times a week	(4) 4 or more times a week
How many drinks containing alcohol do you have on a typical day when you are drinking?	(0) 1-2	(1) 3 or 4	(2) 5 or 6	(3) 7 to 9	(4) 10 or more
How often do you have six or more drinks on one occasion?	(0) Never	(1) Less than monthly	(2) Monthly	(3) Weekly	(4) Daily or almost daily
How often during the last year have you found that you were unable to stop drinking once you started?	(0) Never	(1) Less than monthly	(2) Monthly	(3) Weekly	(4) Daily or almost daily
How often during the last year have you failed to do what was normally expected of you because of drinking?	(0) Never	(1) Less than monthly	(2) Monthly	(3) Weekly	(4) Daily or almost daily
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	(0) Never	(1) Less than monthly	(2) Monthly	(3) Weekly	(4) Daily or almost daily
How often during the last year have you been unable to remember what happened the night before because of drinking?	(0) Never	(1) Less than monthly	(2) Monthly	(3) Weekly	(4) Daily or almost daily
Have you or someone else been injured as the result of your drinking?	(0) NO	(2) YES, but not in the last year	(4) YES, during the last year		
Has a friend, relative or doctor or other health worker been concerned about your drinking or suggested you cut down?	(0) NO	(2) YES, but not in the last year	(4) YES, during the last year		
FOR OFFICE USE : Total Score_____					

HISTORY OF INTERPERSONAL TRAUMA	Never	Some times	Often	Very often
1. When I was growing up, people in my family hit me so hard, I had bruises or marks	1	2	3	4
2. When I was growing up, someone tried to touch me in a sexual way or tried to make me touch them	1	2	3	4
3. Have you ever been in a relationship where your partner has pushed or slapped you?	YES		NO	
4. Have you ever been in a relationship where your partner has threatened you with violence?	YES		NO	
5. Have you ever been in a relationship where your partner has thrown, broken or punched things?	YES		NO	
FOR OFFICE USE: Total Score Items 1 & 2:_____				

Patient Name:_____DOB:_____MR#_____

Problems with using medication or other drugs-DAST Questionnaire *These questions refer to the past 12 months*		
Have you used drugs or prescription medications in ways other than those required for medical reasons?	Yes	No
Have you used more than one drug or medication at the same time?	Yes	No
Have you been unable to stop using drugs or medication when you wanted to?	Yes	No
Have you ever had blackouts or flashbacks as a result of drug or medication use?	Yes	No
Have you ever felt bad or guilty about your drug or medication use?	Yes	No
Has a relative or friend ever complained about your use of drugs or medications?	Yes	No
Have you ever neglected your family because of your use of drugs or medications?	Yes	No
Have you engaged in illegal activities in order to obtain drugs or medications?	Yes	No
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs or medications?	Yes	No
Have you had medical problems as a result of your drug or medication use (eg memory loss, hepatitis, seizures)?	Yes	No
For OFFICE USE ONLY: Total score:_____		

Goal Setting

Think of a time when you were more able to do things you enjoy. What were those things that you would like to be able to do again if you had less pain? (like : exercise, garden; clean the house, find a job, play with grandchild, have intimacy or a better relationship with spouse/partner)

1. _____

2. _____

3. _____

Goal Setting

List three steps you can take to work towards doing **one** of the things you have had to give up because of pain:

1. _____ 2. _____ 3. _____

What barriers will you have to overcome to work on your goals? (e.g., time, money, influences of friends/family, attitude)

1. _____ 2. _____ 3. _____