

Frankston Pain Management

Interventional and Interdisciplinary Pain Management

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Email: info@fpmx.com.au Web site: www.fpmx.com.au

Dear _____,

Thank you for completing the questionnaires and registration form. **Please use a black or blue pen** to answer the questions (please do not use a pencil as it does not scan well). We use this information to see how your pain affects your life, to plan and monitor your treatment.

Suffering from severe pain for a long time frequently makes things difficult for you and your family. These questionnaires are not designed to “trick you” or see if the pain is “in your head”, rather, the questionnaires show us how the pain has affected your activity, mood, enjoyment of life and lifestyle.

The different forms tell us about the onset, timing and impact of your pain.

- The Patient Information and Pain History questionnaires tells us about you, your pain, general health, previous treatments and current medication usage.
- The Pain Detect Questionnaire has a body diagram for you to show us where you have pain and questions about intensity and character of your pain.
- The DASS questionnaire is used to see how the pain affects your mood.
- The SF-36 questionnaire is used to provide more information on your overall health status and how your pain interferes with your daily life.
- The Activity Diary is for you to show us what happens in your life over two days.

Instructions for this diary are on the other side of the diary.

Please read and follow the instructions on each form. Please feel free to contact the rooms at any time if you have any queries.

If you have difficulty completing the forms, please ask your general practitioner or a trusted friend for assistance. For \$30, our admin staff can also help you complete the forms.

Please note that you must return ALL forms (except Activity Diary) before we can give you an appointment. Please return the forms by email to info@fpmx.com.au, fax to 03 9770 0944 or post/hand to 7/20 Clarendon Street, Frankston 3199. Please keep the 2-day Activity Diary and give it to the receptionist at your visit.

Kind regards,

Dr Murray Taverner

“Maximising Function, Minimising Pain and Suffering”

Patient Registration Form

PATIENT INFORMATION:		
Given Name (include Title):	Surname:	DOB:
Address:		Postal Code:
Home Phone:	Work Phone:	Mobile:
Email Address		

NEXT OF KIN/EMERGENCY CONTACT:	
Given Name:	Surname:
Contact No:	Relationship to Patient:

DOCTOR'S INFORMATION:		
GP's Name:	Phone:	Fax:
Address:		Postal Code:
Referring Doctor (if different):		
Other Health Professionals:		

INSURANCE DETAILS:		
Medicare Number:	Expiry Date:	
Health Insurance Fund:	Membership No:	Gap Cover? <input type="checkbox"/> Yes <input type="checkbox"/> No
Pension Number:	<input type="checkbox"/> Disability <input type="checkbox"/> Old Age <input type="checkbox"/> Others	
Veterans' Affairs No:	<input type="checkbox"/> Gold <input type="checkbox"/> White	
TAC or WorkCover Insurer Name:	Claim No:	
	DOA:	
Claims Officer's Name:	Direct Tel:	
	Direct Fax:	
Employer's Name:		

I authorise Frankston Pain Management to obtain copies of letters, reports and investigation results and to correspond with or discuss my treatment plan with other treating health professionals.

I have read and I accept Dr _____ professional fees and payment arrangements as described in the brief fee schedule dated _____.

I am aware that there may be a gap between the fees charged and my refund and that it is my responsibility to pay the gap amount. I agree to pay all doctors' fees on the day of consultation.

Signed: _____

Date: _____

Health Information Collection Consent Form

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

Your Privacy

The doctors, health professionals and other staff of Frankston Pain Management Group are all committed to respecting your confidence and preserving your privacy as required by Law. This obligation extends to other people having lawful access to your personal information.(eg external typists)

Collection, use and disclosure of your information

Information about a patient's medical, family and general health history is needed to properly assess, diagnose, treat and be proactive in your health care needs. We will be fair in the way we collect information about our patients. This information is generally collected from the patient, and otherwise with the patient's consent. However, from time to time we may receive patient information from others. When this occurs we will, wherever possible, make sure the patient knows we have received this information. Some information is used for appointment reminders/recalls and some is also provided to Medicare, private health funds, Workcover and TAC if relevant, for billing, medical rebate or debt recovery purposes.

Medical care requires full knowledge of patient health information by all members of a medical team. To ensure quality and continuity of patient care a patient's health information has to be shared with other health care providers from time to time. In emergencies, this may involve disclosure of relevant information without consent.

The doctors and health professionals in this practice are members of various medical and professional bodies including medical defence organisations. There may be occasions when disclosure of patient information is required for medical defence or quality improvement purposes.

There are also circumstances where a medical practitioner or health professional is legally bound to disclose personal information. An example of this is the mandatory reporting of communicable diseases.

Anonymous patient information may be used in funding requests, management, planning, quality improvement or evaluation of health services, whilst ensuring that all reasonable steps are taken to maintain confidentiality.

It is necessary for us to keep patients' information after their last attendance at this practice for as long as is required by law or is prudent having regard to administrative requirements.

Access

A patient has a right to access their information. They may ask to view the information or ask for a copy of a part or of the whole record. While not required to give reasons for their request, a patient may be asked to clarify the scope of the request.

There are some circumstances in which access may be denied but in such an event, the patient will be advised of the reason. A charge may be payable where the practice incurs costs in providing access. This will depend on the nature of the access.

The material over which the doctor has copyright might be subject to conditions that prevent further copying or publication without the doctor's permission.

If a patient finds that the information held on them is not accurate or complete, the patient may have that information amended accordingly

Upon request a patient's health information held by this practice will be made available to another health service provider. This may incur a charge to cover costs.

Parents/guardians and children

The right of children to privacy of their health information, based on the professional judgment of the doctor and consistent with the law, might at times restrict access to this information by parents or guardians.

Complaints

It is important to us that your expectations about the way in which we handle your information are the same as ours.

Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your doctor.

If you still dissatisfied you can complain to the Federal Privacy Commissioner whose contact details are:

GPO Box 5218 Sydney NSW 1042;

Privacy Hotline: 1300 363 992;

Website: www.privacy.gov.au

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice about.

Signed: _____

Date: _____

Patient Information Questionnaire

Today's Date _____

Did you need help filling out this questionnaire?

☐ No help needed ☐ Family Member ☐ Friend ☐ Health Care Professional

Patient Information:		
Given Name:	Surname:	DOB:
Country of Birth:	Year of arrival (if applicable):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Current marital status?	<input type="checkbox"/> Married <input type="checkbox"/> De Facto <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed	
Living Arrangements? (Please tick one)	<input type="checkbox"/> Alone <input type="checkbox"/> Husband/wife/partner/children <input type="checkbox"/> Child/children only <input type="checkbox"/> Parents/ other relatives <input type="checkbox"/> Husband/ wife/ partner <input type="checkbox"/> Friends/Flatmates	
Highest level of education: (Please tick one)	<input type="checkbox"/> Less than 3 years in secondary school <input type="checkbox"/> TAFE / Technical College <input type="checkbox"/> School Cert/ Intermediate <input type="checkbox"/> University / CAE <input type="checkbox"/> HSC/ Leaving Certificate <input type="checkbox"/> Others	

(Before Injury) Work Status:	
What was your main occupation before your pain/injury?	
How many hours per week were you working before your pain/injury?	

(After Injury) Work Status:	
Are you currently:	
Working	<input type="checkbox"/> Normal Duties <input type="checkbox"/> Modified Duties <input type="checkbox"/> Normal Hours <input type="checkbox"/> Modified Hours – how many hours per week? _____
	How many days sick leave was used? Last month _____ Last year _____
Not working from pain/injury	Date last worked _____
Not working for other reasons:	<input type="checkbox"/> Voluntary Work <input type="checkbox"/> Home Duties <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Retraining <input type="checkbox"/> Others _____

Other Details:	
How did your pain begin? (tick one which applies BEST)	<input type="checkbox"/> Accident at work <input type="checkbox"/> Car Accident <input type="checkbox"/> After an illness <input type="checkbox"/> At work, but not involving accident <input type="checkbox"/> Sporting Accident <input type="checkbox"/> Pain just began <input type="checkbox"/> Accident at home <input type="checkbox"/> After Surgery <input type="checkbox"/> Other reasons
Is this visit related to a compensation claim?	<input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Some other legal case? <input type="checkbox"/> Motor Accident Compensation <input type="checkbox"/> None of the above
Has your claim been settled?	<input type="checkbox"/> Yes When was it settled? _____ <input type="checkbox"/> No <input type="checkbox"/> Not applicable
Current Source of Income (You may tick more than one)	<input type="checkbox"/> Worker's Compensation insurance <input type="checkbox"/> Unemployment/Job Search benefits <input type="checkbox"/> Sickness Benefits <input type="checkbox"/> Supporting parents benefits <input type="checkbox"/> Age Pension <input type="checkbox"/> Superannuation payments <input type="checkbox"/> Disability/ Invalid pension <input type="checkbox"/> Savings/investment <input type="checkbox"/> Partner/wife/husband earnings <input type="checkbox"/> Austudy <input type="checkbox"/> Wages/ Salary <input type="checkbox"/> TAC <input type="checkbox"/> Self Employed <input type="checkbox"/> Others (specify) _____

Pain History

Today's Date _____

1. When did your pain first start? Please be exact as possible
DAY _____ MONTH _____ YEAR _____
2. If your pain comes and goes, when did the **present episode** of pain start? (if different from Question 1)
DAY _____ MONTH _____ YEAR _____
3. How many tablets do you take for pain each day? _____
4. How many tablets do you take for reasons other than pain each day? _____
5. **Pain Sites:** (please rate each of you pain(s) using a 0-10 scale with 0 being no pain and 10 being worst imaginable pain).
Leave the space blank if you do not have pain in that area.

Sites	Left	Right	Sites	Left	Right	Sites	Left	Right
Head – front			Elbow			Buttocks		
Head-Back			Forearm			Hip		
Face			Wrist/Hand			Thigh		
Neck			Chest			Knee		
Shoulder			Abdomen			Lower Leg		
Upper Back			Midback			Ankle/ foot		
Upper Arm			Low Back			Groin		

Please rank the 5 worst pains location

1. _____
2. _____
3. _____
4. _____
5. _____

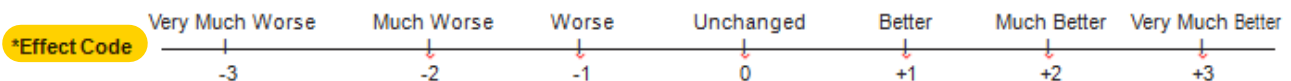
6. Location of **Main Pain**: ☐ Dominant Side ☐ Non-Dominant side ☐ Both sides

7. Which statement best describes your main pain?

- | | |
|--|--|
| <input type="checkbox"/> Single episode, limited duration | <input type="checkbox"/> Paroxysmal (short attacks) |
| <input type="checkbox"/> Continuous or nearly continuous, same intensity | <input type="checkbox"/> Sustained with superimposed paroxysms |
| <input type="checkbox"/> Continuous or nearly continuous, variable intensity | <input type="checkbox"/> Other combinations _____ |
| <input type="checkbox"/> Recurring regularly | <input type="checkbox"/> None of these |
| <input type="checkbox"/> Recurring irregularly | <input type="checkbox"/> Not applicable |

8. Who of the following have you seen about your pain? Since it started? In the last 3 months? How effective/helpful?

	Visits Since Start	Visits Last 3 months	Effect*		Visits Since Start	Visits Last 3 months	Effect*		Visits Since Start	Visits Last 3 months	Effect*
Acupuncturist				Neurologist				Psychologist			
Anaesthetist				Neurosurgeon				Rehab Physician			
Chiropractor				Occ. Therapist				Rheumatologist			
General Practitioner				Ortho. Surgeon				Sports Med. Doctor			
AH GP/Locum calls				Pain Clinic				Massage & others			
Naturo/Homeopath				Physiotherapist				Medicolegal Exams			
Hydrotherapist				Psychiatrist				Accident & Emergency			
Hypnotherapist				Exercise Therapist				Days in Hospital =			



9. Task Performance – Please list 4 goals/tasks/things that your pain prevents/limits you from doing.

Does the main problem limit any of your activities <input type="checkbox"/> YES <input type="checkbox"/> NO					
Please list the 4 activities and indicate how much they are limited by you	CANNOT DO AT ALL	CAN DO BUT SEVERELY LIMITED	CAN DO BUT MODERATELY LIMITED	CAN DO BUT SLIGHTLY LIMITED	CAN DO WITHOUT LIMITATION
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Today's Date _____

Health Survey

Tick if you have ever had any of the following:

<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Stomach Ulcer Bowel	<input type="checkbox"/>	Hepatitis (A/B/C)
<input type="checkbox"/>	Blood clots in the legs/lungs	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Bleeding Recurrent	<input type="checkbox"/>	AIDS risk
<input type="checkbox"/>	Angina	<input type="checkbox"/>	Chronic Lung Disease	<input type="checkbox"/>	Diarrhoea Chronic	<input type="checkbox"/>	Steroids (cortisone)
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Sleep Apnoea	<input type="checkbox"/>	Constipation Kidney	<input type="checkbox"/>	Bleeding Tendency
<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	Mental, Emotional Disorder	<input type="checkbox"/>	Disease Trouble	<input type="checkbox"/>	Anticoagulants
<input type="checkbox"/>	Irregular heartbeat (AF)	<input type="checkbox"/>	Alzheimer's or Dementia	<input type="checkbox"/>	Passing Urine	<input type="checkbox"/>	Anaemia
<input type="checkbox"/>	Stroke or mini-stroke	<input type="checkbox"/>	Fall in last 6 months	<input type="checkbox"/>	Cancer or Chemotherapy	<input type="checkbox"/>	Blood Transfusion
<input type="checkbox"/>	Pacemaker/ Defibrillator	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Fevers	<input type="checkbox"/>	Transfusion reaction
<input type="checkbox"/>	Breathlessness: Rest/Walk	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	Diabetes: Insulin, Oral, Diet	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Unexpected weight loss	<input type="checkbox"/>	Latex Allergy
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Hiatus Hernia/ Reflux	<input type="checkbox"/>	Reaction to IV Contrast	<input type="checkbox"/>	Anaesthetic problem

How tall are you?..... How much do you weigh? What is your waist circumference (cm)?

Any other Medical History:

Surgical History

Past Pain Treatments Questionnaire

What was done?	When (approx)	Who did it?	How Successful? (Use the Effect Code Below)
<div> <div>*Effect Code</div> <div> <div>Very Much Worse</div> <div>Much Worse</div> <div>Worse</div> <div>Unchanged</div> <div>Better</div> <div>Much Better</div> <div>Very Much Better</div> </div> <div> <div>-3</div> <div>-2</div> <div>-1</div> <div>0</div> <div>+1</div> <div>+2</div> <div>+3</div> </div> </div>			

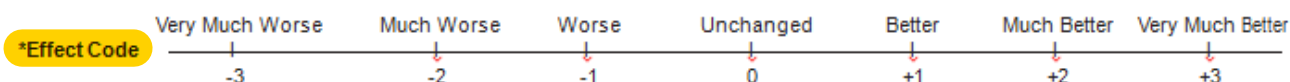
Attach Another Page if more space is needed

Past Drugs

Drugs	Dose and Frequency	Duration	*Effect Code	Effects and Side Effects Description	Why Ceased?

Current Drugs

Drugs	Dose and Frequency	Duration	*Effect Code	Effects and Side Effects Description	Why Ceased?



Allergies

CAGE – AID

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever felt you should C ut down on your use of alcohol or drugs?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been A nnoyed when people have commented on your use?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever felt G uilty or bad about your use?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever used alcohol or drugs to E ase withdrawal symptoms, or to avoid feeling low?

Alcohol	<input type="checkbox"/> No	<input type="checkbox"/> Yes. How much? <input type="checkbox"/> <2 <input type="checkbox"/> 3-6 <input type="checkbox"/> 7+	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly
Smoker:	<input type="checkbox"/> Never	<input type="checkbox"/> Ex-smoker. Age you quit ____	<input type="checkbox"/> Smoker	Age started ____	No of sticks? ____
Other Drugs:	<input type="checkbox"/> Never	<input type="checkbox"/> Quit. Age you quit ____	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly

Your Story

Instructions: Please fill in the sections below following a logical date or sequence order.
Please be as brief and accurate as possible as this saves time (and money) during the consultation.
Please use more paper or copy the headings on to your own paper if needed.

Your Story: Describe the sequence of events from the onset of your problem/pain until now.

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There are no margins, text, or other markings on the paper.

Describe your Pain(s): Describe up to 3 pains using the following headings.

How did your pain start; what words best describe pains; pain location(s); pain intensity (0-10/10 no pain - worst imaginable pain scale); what makes the pain better or worse; what treatments have you tried and how well did/do they work? Attach extra page if needed.

[illegible]

Describe the Impact of Pain on:

Personal Care, Domestic, Community, Work (paid/unpaid), Social activities and Emotions

[illegible]

FPM Extra Questions

Today's Date _____

Major life events may affect your answers to this questionnaire. Please indicate whether you have experienced any of the events listed below (or similar events)

Please tick any of the following life events you have experienced? Please also tick if the event happened in the last 12 months.

Situation	Date	Situation	Date	Situation	Date
<input type="checkbox"/> Death of a spouse		<input type="checkbox"/> Divorce or marital separation		<input type="checkbox"/> Loss of employment	
<input type="checkbox"/> Death of a close family member		<input type="checkbox"/> Problems with children		<input type="checkbox"/> Financial Difficulties	
<input type="checkbox"/> Personal illness or injury		<input type="checkbox"/> Road traffic accident		<input type="checkbox"/> Retired	
<input type="checkbox"/> Change of address		<input type="checkbox"/> Accident at Work		<input type="checkbox"/> Jail term	
<input type="checkbox"/> In-Law problems		<input type="checkbox"/> Work/ School problems		<input type="checkbox"/> Minor violation of the law	
<input type="checkbox"/> Family problems		<input type="checkbox"/> Illness of a close family member		<input type="checkbox"/> Hospital admission/s	
<input type="checkbox"/> Marital problems		<input type="checkbox"/> Pregnancy/ Birth			

What makes the pain worse? (You may tick more than one)

<input type="checkbox"/> Sitting	<input type="checkbox"/> Household chores	<input type="checkbox"/> Hot weather	<input type="checkbox"/> Sex
<input type="checkbox"/> Standing	<input type="checkbox"/> Everything	<input type="checkbox"/> Cold weather	<input type="checkbox"/> Stress
<input type="checkbox"/> Lying down	<input type="checkbox"/> Loud noise	<input type="checkbox"/> Weather changes	<input type="checkbox"/> Tension
<input type="checkbox"/> Lifting	<input type="checkbox"/> Working	<input type="checkbox"/> Walking	<input type="checkbox"/> Driving
<input type="checkbox"/> Bending	<input type="checkbox"/> Any movement	<input type="checkbox"/> Swimming	<input type="checkbox"/> Stairs and inclines
<input type="checkbox"/> Nothing	<input type="checkbox"/> Not moving	<input type="checkbox"/> Cycling	<input type="checkbox"/> Other _____

What makes the pain better? (You may tick more than one)

<input type="checkbox"/> Sitting	<input type="checkbox"/> Exercise	<input type="checkbox"/> Hot weather	<input type="checkbox"/> Sex
<input type="checkbox"/> Standing	<input type="checkbox"/> Working	<input type="checkbox"/> Cold weather	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Lying down	<input type="checkbox"/> Warm/Hot Bath	<input type="checkbox"/> Pressure	<input type="checkbox"/> Rest
<input type="checkbox"/> Stretching	<input type="checkbox"/> Warm/ Hot shower	<input type="checkbox"/> Massage/ rubbing	<input type="checkbox"/> Being with others
<input type="checkbox"/> Relaxing	<input type="checkbox"/> Tablets	<input type="checkbox"/> Walking	<input type="checkbox"/> Pacing
<input type="checkbox"/> Reading	<input type="checkbox"/> Hot/Cold packs	<input type="checkbox"/> Cycling	<input type="checkbox"/> Keep busy
<input type="checkbox"/> Watching TV	<input type="checkbox"/> TENS	<input type="checkbox"/> Swimming	<input type="checkbox"/> Nothing
<input type="checkbox"/> Other: _____			

Pain Detect

Today's Date _____

How would you assess your pain – now, at this moment?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10
none										max

How strong was the strongest pain during the past 4 weeks?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10
none										max

How strong was your pain on average during the past 4 weeks?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10
none										max

Mark the picture that best describes the course of your pain



Persistent pain with Slight fluctuations

☐


Persistent pain with pain attacks

☐


Pain attacks without pain between them

☐


Pain attacks with pain between them

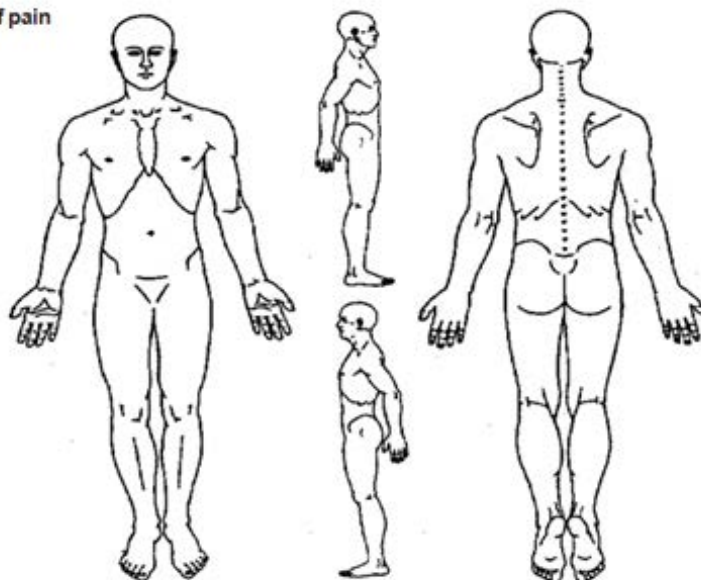
☐

Please mark your main area of pain

Does your pain radiate to other regions of your body?

☐ Yes ☐ No

If yes, please draw the direction in which the pain radiates.



	Never	Hardly notice	Slightly	Moderately	Strongly	Very Strongly
Do you suffer from a burning sensation (e.g. stinging nettles) in the marked areas?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you having a tingling or prickling sensation in the area of your pain (like crawling ants or electrical tingling)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is light touching (clothing, blanket) in this area painful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have sudden pain attacks in the areas of your pain, like electrical shocks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is cold or heat (bath water) in this area occasionally painful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from a sensation of numbness in the areas that you marked?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does slight pressure in this area (e.g. with a finger) trigger pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total Score: _____ out of 35	0 = _____	1 = _____	2 = _____	3 = _____	4 = _____	5 = _____

Office Use Only

DASS-21

Today's Date _____

Please read each statement and tick the corresponding number which indicates how much the statement applied to you **over the past week**. There are no right or wrong answers. Do not spend too much time on each statement. (Please tick one only)

The rating scale is as follows:

0. Did not apply to me at all.
1. Applied to me to some degree, or some of the time.
2. Applied to me to a considerable degree, or a good part of time
3. Applied to me very much, or most of the time.

Statement	0	1	2	3
1. I found it hard to wind down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I was aware of the dryness of my mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I couldn't seem to experience any positive feeling at all.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I experienced breathing difficulty (excessively rapid breathing, breathlessness in the absence of physical exertion).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I found it difficult to work up the initiative to do things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I tended to over-react to situations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I experienced trembling (e.g. in the hands).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I felt that I was using a lot of nervous energy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I was worried about situations in which I might panic and make a fool of myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I felt that I had nothing to look forward to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I found myself getting agitated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I found it difficult to relax.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I felt down-hearted and blue.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I was intolerant of anything that kept me from getting on with what I was doing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I felt I was close to panic.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I was unable to become enthusiastic about anything.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I felt I wasn't worth much as a person.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I felt that I was rather touchy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I felt scared without any good reason.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I felt that life was meaningless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SF-36

Today's Date _____

Instructions: To be completed by the patient. This questionnaire asks for your views about your health, how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1 In general, would you say your health is

Excellent	<input type="checkbox"/> 1
Very good	<input type="checkbox"/> 2
Good	<input type="checkbox"/> 3
Fair	<input type="checkbox"/> 4
Poor	<input type="checkbox"/> 5

2 Compared to one year ago, how would you rate your health in general now?

Much better now than a year ago	<input type="checkbox"/> 1
Somewhat better now than one year ago	<input type="checkbox"/> 2
About the same as one year ago	<input type="checkbox"/> 3
Somewhat worse now than one year ago	<input type="checkbox"/> 4
Much worse now than one year ago.	<input type="checkbox"/> 5

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Please tick one number on each line only)

Activities	Yes, limited a lot	Yes, limited a little	No, not limited at all
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sport	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Lifting or carrying groceries	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Climbing several flights of stairs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Climbing one flight of stairs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Bending, kneeling or stooping	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Walking more than one kilometre (1km)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Walking half a kilometre (500m)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Walking 100 metres (100m)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Bathing and dressing yourself	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

4. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**? (Please tick one number on each line only)

	Yes	No
Cut down on the amount of time you spent on work or other activities	<input type="checkbox"/> 1	<input type="checkbox"/> 2
Accomplished less than you would like	<input type="checkbox"/> 1	<input type="checkbox"/> 2
Were limited in the kind of work or other activities	<input type="checkbox"/> 1	<input type="checkbox"/> 2
Had difficulty performing the work or other activities (for example, it took extra effort)	<input type="checkbox"/> 1	<input type="checkbox"/> 2

5. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)? (Please tick one number on each line only)

	Yes	No
Cut down on the amount of time you spent on work or other activities	<input type="checkbox"/> 1	<input type="checkbox"/> 2
Accomplished less than you would like	<input type="checkbox"/> 1	<input type="checkbox"/> 2
Didn't do work or any activities as carefully as usual	<input type="checkbox"/> 1	<input type="checkbox"/> 2

6 During the **past 4 weeks**, to what extent has your physical health or emotional **problems interfered with your normal social activities** with family, friends, neighbours or groups? (Please tick one only)

Not at all	<input type="checkbox"/> 1
Slightly	<input type="checkbox"/> 2
Moderately	<input type="checkbox"/> 3
Quite a bit	<input type="checkbox"/> 4
Extremely	<input type="checkbox"/> 5

7 How much **bodily pain** have you had during the **past 4 weeks**? (Please tick one only).

No bodily pain	<input type="checkbox"/> 1
Very mild	<input type="checkbox"/> 2
Mild	<input type="checkbox"/> 3
Moderate	<input type="checkbox"/> 4
Severe	<input type="checkbox"/> 5
Very Severe	<input type="checkbox"/> 6

8. During the **past 4 weeks**, how much did pain **interfere with your normal work** (including both work outside the home and housework)? (Please tick one only).

Not at all	<input type="checkbox"/> 1
A little bit	<input type="checkbox"/> 2
Moderately	<input type="checkbox"/> 3
Quite a bit	<input type="checkbox"/> 4
Extremely	<input type="checkbox"/> 5

9. These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much time during the past 4 weeks -	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Did you feel full of life?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Have you been a very nervous person?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Have you felt calm and peaceful?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Did you have a lot of energy?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Have you felt downhearted and blue?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Did you feel worn out?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Have you been a happy person?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Did you feel tired?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives etc.)?

All of the time	<input type="checkbox"/> 1
Most of the time	<input type="checkbox"/> 2
Some of the time	<input type="checkbox"/> 3
A little of the time	<input type="checkbox"/> 4
None of the time	<input type="checkbox"/> 5

11 How TRUE or FALSE is each of the following statements for you? (Please tick one number only)

	Definitely True	Mostly True	Not Sure	Mostly False	Definitely False
I seem to get sick a little easier than other people	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I am as health as anyone I know	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I expect my health to get worse	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
My health is excellent	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Please return to:
Frankston Pain Management
 7/20 Clarendon Street, Frankston, VIC 3199
 Tel: 9770 0522 Fax: 9770 0944
 Email: info@fpmx.com.au

Name: _____ Day: _____ Date: _____

ACTIVITY DIARY

Diary from (date): _____ to (date) _____

It is important that you keep this diary for 2 days, preferably the 2 days preceding your appointment. It is easier to be accurate if you record your actions and responses several times per day (do not fill out the whole day in the evening). Please indicate the major activity you were doing during each 4 hour period (independent of whether you had pain or not). Write what you were doing under the position you were in for that action (i.e. Sitting, walking/standing, lying down).

Please indicate your mood by making a mark in the appropriate box (i.e. Happy/ elated, neither happy nor sad, sad and depressed). Please record the pain intensity by inserting a tick in the appropriate pain level space, using a scale of 0-10 (see below).

Think of the most painful experience you have had in your life. Use that experience as the comparison to judge the pain you presently feel. Take the example of the most painful experience as an example of 10 on the scale.

0 = No pain

2 = Mild pain present but can be easily ignored




4 = Discomforting pain present, cannot be ignored, but does not limit activity

6 = Distressing pain, cannot be ignored, interferes with concentration

8 = Horrible pain, cannot be ignored, limits all tasks, except basic needs (eating and toilet visits, etc.)

10 = Excruciating pain present, cannot be ignored, rest or bed rest required

If you were taking any medications, write in amount, dosage, and type of medication you took as shown in the example. Include any alcoholic beverages you have taken, listing type, size and quantity in the medication space. Use attached notes if more space is required.

	Sitting		Walking & Standing		Lying Down		Mood			Medication & Alcohol			Pain Level					
	Major Activity	Time	Major Activity	Time	Major Activity	Time				Brand Name	Dose	Qty.	0	2	4	6	8	10
12-4 am																		
4-8 am																		

ACTIVITY DIARY DAY 1

Name: _____ Day: _____ Date: _____

	Sitting		Walking & Standing		Lying Down		Mood			Medication & Alcohol			Pain Level						
	Major Activity	Time	Major Activity	Time	Major Activity	Time	😊	😐	😞	Brand Name	Dose	Qty.	0	2	4	6	8	10	
12-4 am																			
4-8 am																			
8-12 MD																			
12-4 pm																			
4-8 pm																			
8-12 MN																			

ACTIVITY DIARY DAY 2

	Sitting		Walking & Standing		Lying Down		Mood			Medication & Alcohol			Pain Level						
	Major Activity	Time	Major Activity	Time	Major Activity	Time	😊	😐	😞	Brand Name	Dose	Qty.	0	2	4	6	8	10	
12-4 am																			
4-8 am																			
8-12 MD																			
12-4 pm																			
4-8 pm																			
8-12 MN																			
			Total Hours:		Total Hours:		0 = No Pain 10 = Excruciating pain												