# Frankston Pain Management

Interventional and Interdisciplinary Pain Management

7/20 Clarendon St, Frankston, Vic, 3199
Tel: 03 9770 0522, Fax: 03 9770 0944
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

# Patient Registration Form

| PATIENT INFORMATION: | | |
|---|---|---|
| **Given Name *(include Title)*:** | **Surname:** | **DOB:** |
| **Preferred Name:** | | |
| 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? ☐ Yes ☐ No |
| Pension Number: | | ☐ Disability ☐ Old Age ☐ Others |
| Veterans' Affairs No: | | ☐ Gold ☐ White |
| TAC or WorkCover Insurer Name: | | Claim No: |
| | | DOA: |
| Claims Officer's Name: | | Direct Tel: |
| | | Direct Fax: |
| Employer's Name: | | |

I authorize 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 _____ professional fees and payment arrangements as described in the brief fee schedule Dr 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: ☐ Male ☐ Female |
| Current marital status? | ☐ Married ☐ De Facto ☐ Divorced ☐ Separated ☐ Single ☐ Widowed | |
| Living Arrangements? (Please tick one) | ☐ Alone ☐ Husband/wife/partner/children ☐ Child/children only<br>☐ Parents/ other relatives ☐ Husband/ wife/ partner ☐ Friends/Flatmates | |
| Highest level of education: (Please tick one) | ☐ Less than 3 years in secondary school ☐ TAFE / Technical College<br>☐ School Cert/ Intermediate ☐ University / CAE<br>☐ HSC/ Leaving Certificate ☐ 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 | ☐ Normal Duties ☐ Modified Duties<br>☐ Normal Hours ☐ Modified Hours – how many hours per week? _____<br>How many days sick leave was used? Last month _____ Last year _____ | |
| Not working from pain/injury | Date last worked _____ | |
| Not working for other reasons: | ☐ Voluntary Work<br>☐ Retired<br>☐ Retraining | ☐ Home Duties<br>☐ Student<br>☐ Others _____ |

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

- ☐ Single episode, limited duration
- ☐ Continuous or nearly continuous, same intensity
- ☐ Continuous or nearly continuous, variable intensity
- ☐ Recurring regularly
- ☐ Recurring irregularly
- ☐ Paroxysmal (short attacks)
- ☐ Sustained with superimposed paroxysms
- ☐ Other combinations _____
- ☐ None of these
- ☐ 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 = | | | |

*Effect Code: Very Much Worse (-3) | Much Worse (-2) | Worse (-1) | Unchanged (0) | Better (+1) | Much Better (+2) | Very Much Better (+3)

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** ☐ YES ☐ NO | | | | | |
|---|---|---|---|---|---|
| Please list the 4 activities and indicate how much they are limited by you | CANNOT DO AT ALL | CAN DO BUT SEVERLY LIMITED | CAN DO BUT MODERATELY LIMITED | CAN DO BUT SLIGHTLY LIMITED | CAN DO WITHOUT LIMITATION |
| 1. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. | ☐ | ☐ | ☐ | ☐ | ☐ |

Today's Date _____

## Health Survey

Tick if you have ever had any of the following:

| | | | |
|---|---|---|---|
| ☐ High Blood Pressure | ☐ Pneumonia | ☐ Stomach Ulcer | ☐ Hepatitis ___ (A/B/C) |
| ☐ Blood clots in the legs/lungs | ☐ Tuberculosis | ☐ Bowel Bleeding | ☐ AIDS risk |
| ☐ Angina | ☐ Chronic Lung Disease | ☐ Recurrent Diarrhoea | ☐ Steroids (cortisone) |
| ☐ Heart Attack | ☐ Sleep Apnoea | ☐ Chronic Constipation | ☐ Bleeding Tendency |
| ☐ Congestive Heart Failure | ☐ Mental, Emotional Disorder | ☐ Kidney Disease | ☐ Anticoagulants |
| ☐ Irregular heartbeat (AF) | ☐ Alzheimer's or Dementia | ☐ Trouble Passing Urine | ☐ Anaemia |
| ☐ Stroke or mini-stroke | ☐ Fall in last 6 months | ☐ Cancer or Chemotherapy | ☐ Blood Transfusion |
| ☐ Pacemaker/ Defibrillator | ☐ Arthritis | ☐ Fevers | ☐ Transfusion reaction |
| ☐ Breathlessness: Rest/Walk | ☐ Migraines | ☐ Night sweats | ☐ Eczema |
| ☐ Diabetes: Insulin, Oral, Diet | ☐ Epilepsy | ☐ Unexpected weight loss | ☐ Latex Allergy |
| ☐ Asthma | ☐ Hiatus Hernia/ Reflux | ☐ Reaction to IV Contrast | ☐ 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) |
|---|---|---|---|
| *Effect Code: Very Much Worse -3; Much Worse -2; Worse -1; Unchanged 0; Better +1; Much Better +2; Very Much Better +3 | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

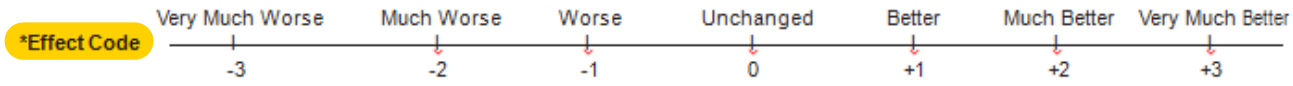
**Attach Another Page if more space is needed**

## 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

| | | |
|---|---|---|
| ☐ Yes | ☐ No | Have you ever felt you should **C**ut down on your use of alcohol or drugs? |
| ☐ Yes | ☐ No | Have you ever been **A**nnoyed when people have commented on your use? |
| ☐ Yes | ☐ No | Have you ever felt **G**uilty or bad about your use? |
| ☐ Yes | ☐ No | Have you ever used alcohol or drugs to **E**ase withdrawal symptoms, or to avoid feeling low? |

| | | | |
|---|---|---|---|
| **Alcohol** | ☐ No | ☐ Yes. How much? ☐ <2 ☐ 3-6 ☐ 7+ | ☐ Daily ☐ Weekly ☐ Monthly |
| **Smoker:** | ☐ Never | ☐ Ex-smoker. Age you quit ___ | ☐ Smoker Age started ___ No of sticks? ____ |
| **Other Drugs:** | ☐ Never | ☐ Quit. Age you quit ___ Age started ____ | ☐ Daily ☐ Weekly ☐ 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.**

**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.

**Describe the Impact of Pain on:**
Personal Care, Domestic, Community, Work (paid/unpaid), Social activities and Emotions

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

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

| | | | |
|---|---|---|---|
| ☐ Sitting | ☐ Household chores | ☐ Hot weather | ☐ Sex |
| ☐ Standing | ☐ Everything | ☐ Cold weather | ☐ Stress |
| ☐ Lying down | ☐ Loud noise | ☐ Weather changes | ☐ Tension |
| ☐ Lifting | ☐ Working | ☐ Walking | ☐ Driving |
| ☐ Bending | ☐ Any movement | ☐ Swimming | ☐ Stairs and inclines |
| ☐ Nothing | ☐ Not moving | ☐ Cycling | ☐ Other |

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

| | | | |
|---|---|---|---|
| ☐ Sitting | ☐ Exercise | ☐ Hot weather | ☐ Sex |
| ☐ Standing | ☐ Working | ☐ Cold weather | ☐ Alcohol |
| ☐ Lying down | ☐ Warm/Hot Bath | ☐ Pressure | ☐ Rest |
| ☐ Stretching | ☐ Warm/ Hot shower | ☐ Massage/ rubbing | ☐ Being with others |
| ☐ Relaxing | ☐ Tablets | ☐ Walking | ☐ Pacing |
| ☐ Reading | ☐ Hot/Cold packs | ☐ Cycling | ☐ Keep busy |
| ☐ Watching TV | ☐ TENS | ☐ Swimming | ☐ Nothing |
| ☐ Other: | | | |

## Pain Detect

Today's Date _____

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

| ☐ 0 none | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 max |
|---|---|---|---|---|---|---|---|---|---|---|

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

| ☐ 0 none | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 max |
|---|---|---|---|---|---|---|---|---|---|---|

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

| ☐ 0 none | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 | ☐ 7 | ☐ 8 | ☐ 9 | ☐ 10 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 ☐

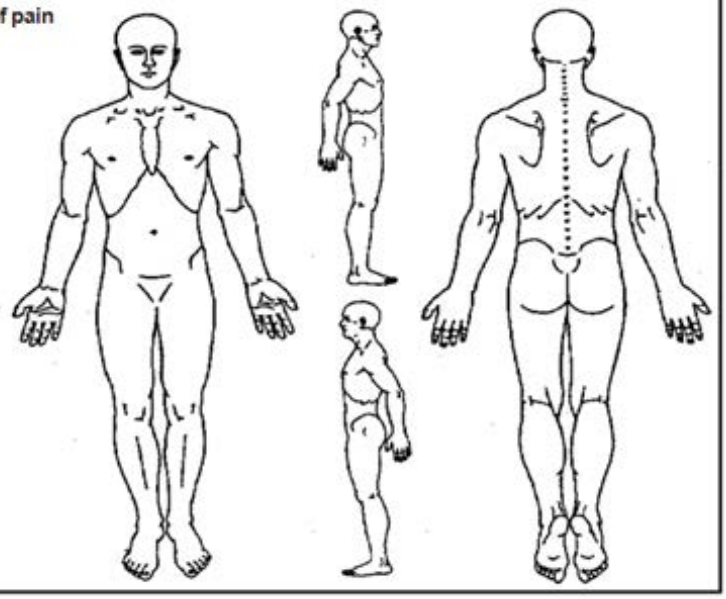

Pain attacks with pain between them ☐

**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? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you having a tingling or prickling sensation in the area of your pain (like crawling ants or electrical tingling)? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Is light touching (clothing, blanket) in this area painful? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you have sudden pain attacks in the areas of your pain, like electrical shocks? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Is cold or heat (bath water) in this area occasionally painful? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you suffer from a sensation of numbness in the areas that you marked? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Does slight pressure in this area (e.g. with a finger) trigger pain? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Office Use Only** **Total Score: _____ out of 35** | 0 = ___ | 1 = ___ | 2 = ___ | 3 = ___ | 4 = ___ | 5 = ___ |

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

## 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 | ☐ 1 |
| Very good | ☐ 2 |
| Good | ☐ 3 |
| Fair | ☐ 4 |
| Poor | ☐ 5 |

**2**

| **Compared to one year ago, how would you rate your health in general now?** | |
|---|---|
| Much better now than a year ago | ☐ 1 |
| Somewhat better now than one year ago | ☐ 2 |
| About the same as one year ago | ☐ 3 |
| Somewhat worse now than one year ago | ☐ 4 |
| Much worse now than one year ago. | ☐ 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 | ☐ 1 | ☐ 2 | ☐ 3 |
| Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf | ☐ 1 | ☐ 2 | ☐ 3 |
| Lifting or carrying groceries | ☐ 1 | ☐ 2 | ☐ 3 |
| Climbing several flights of stairs | ☐ 1 | ☐ 2 | ☐ 3 |
| Climbing one flight of stairs | ☐ 1 | ☐ 2 | ☐ 3 |
| Bending, kneeling or stooping | ☐ 1 | ☐ 2 | ☐ 3 |
| Walking more than one kilometre (1km) | ☐ 1 | ☐ 2 | ☐ 3 |
| Walking half a kilometre (500m) | ☐ 1 | ☐ 2 | ☐ 3 |
| Walking **100** metres (100m) | ☐ 1 | ☐ 2 | ☐ 3 |
| Bathing and dressing yourself | ☐ 1 | ☐ 2 | ☐ 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 | ☐ 1 | ☐ 2 |
| **Accomplished less** than you would like | ☐ 1 | ☐ 2 |
| Were limited in the **kind** of work or other activities | ☐ 1 | ☐ 2 |
| Had **difficulty** performing the work or other activities (for example, it took extra effort) | ☐ 1 | ☐ 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 | ☐ 1 | ☐ 2 |
| **Accomplished less** than you would like | ☐ 1 | ☐ 2 |
| Didn't do work or any activities as **carefully** as usual | ☐ 1 | ☐ 2 |

Today's Date _____

**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 | ☐ 1 |
| Slightly | ☐ 2 |
| Moderately | ☐ 3 |
| Quite a bit | ☐ 4 |
| Extremely | ☐ 5 |

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

| | |
|---|---|
| No bodily pain | ☐ 1 |
| Very mild | ☐ 2 |
| Mild | ☐ 3 |
| Moderate | ☐ 4 |
| Severe | ☐ 5 |
| Very Severe | ☐ 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 | ☐ 1 |
| A little bit | ☐ 2 |
| Moderately | ☐ 3 |
| Quite a bit | ☐ 4 |
| Extremely | ☐ 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? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Have you been a very nervous person? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Have you felt so down in the dumps that nothing could cheer you up? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Have you felt calm and peaceful? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Did you have a lot of energy? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Have you felt downhearted and blue? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Did you feel worn out? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Have you been a happy person? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Did you feel tired? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 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 | ☐ 1 |
| Most of the time | ☐ 2 |
| Some of the time | ☐ 3 |
| A little of the time | ☐ 4 |
| None of the time | ☐ 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 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |
| I am as health as anyone I know | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |
| I expect my health to get worse | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |
| My health is excellent | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 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 by6 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** | | | | | | | | | |