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EMPOWER
PAIN MANAGEMENT PROGRAM

Participant Baseline Questionnaire

TODAY'S DATE *(dd/mm/yyyy):* _____

SECTION 1: YOUR DETAILS

TITLE:	**FAMILY NAME:**	**GIVEN NAME/s:**	**GENDER:**
☐ Mr ☐ Mrs ☐ Ms ☐ Miss			☐ Male ☐ Female
DATE OF BIRTH *(dd/mm/yyyy):*	**HOME PHONE:**	**MOBILE PHONE:**	**EMAIL:**

ADDRESS *(Number, Street, Suburb, Postcode, State):*

COUNTRY OF BIRTH: ☐ Australia ☐ New Zealand ☐ Other, *please specify:*

Do you require an interpreter? ☐ No ☐ Yes, *please specify language:*

Do your require help with written or spoken communication? ☐ Yes ☐ No

Are you hearing or sight impaired? ☐ Yes ☐ No

HEIGHT *(cm):* **WEIGHT** *(kg):*

Are you of Aboriginal or Torres Strait Islander origin? *(more than one may be ticked)*
☐ No
☐ Yes, Aboriginal
☐ Yes, Torres Strait Islander

Have you ever served in the Australian Defence Force? ☐ Yes ☐ No

Are you a client of the Department of Veterans' Affairs or have you received a benefit or support from the Department of Veterans' Affairs? ☐ Yes ☐ No

Is there a compensation case relating to this episode? ☐ Yes ☐ No

If yes, record the type of compensation: ☐ Worker's Compensation ☐ Public Liability ☐ Motor Vehicle ☐ Other, *please specify:*

How did your main pain begin?
☐ Cancer ☐ Medical condition other than cancer
☐ Injury at home ☐ Motor vehicle crash ☐ After surgery ☐ Other, *please specify:*
☐ Injury at work/school ☐ Injury in another setting ☐ No obvious cause

How long has your main pain been present? *(Tick one box only)*
☐ Less than 3 months ☐ 3 to 12 months ☐ 12 months to 2 years ☐ 2 to 5 years ☐ More than 5 years

Which statement best describes your pain? *(Tick one box only)*

☐ Always present *(always the same intensity)*

☐ Always present *(level of pain varies)*

☐ Often present *(pain free periods last less than 6 hours)*

☐ Occasionally present *(pain occurs once to several times per day, lasting up to an hour)*

☐ Rarely present *(pain occurs every few days or weeks)*

Do you have any of the following?

☐ A mental health condition, in particular ☐ PTSD ☐ Anxiety ☐ Depression

☐ Other, *please specify:*

☐ Arthritis (including Rheumatoid/Osteoarthritis)

☐ Muscle, bone or joint problems other than arthritis (including Osteoporosis, Fibromyalgia)

☐ Heart and circulation problems (including Heart Disease, Pacemaker, Blood Disease)

In particular specify if you have: ☐ High Blood Pressure ☐ High Cholesterol

☐ Diabetes

☐ Digestive problems (including IBS, GORD, Stomach Ulcers, Reflux, Bowel Disease)

☐ Respiratory problems (including Asthma, Lung Disease, COPD, Sleep Apnoea)

☐ Neurological problems (including Stroke, Epilepsy, Multiple Sclerosis, Parkinson's Disease)

☐ Cancer

☐ Liver, kidney and pancreas problems (including Pancreatitis, Kidney Disease)

☐ Thyroid problems (including Hyperactive or Hypoactive Thyroid, Graves' Disease)

☐ Any other medical conditions, *please specify:*

HEALTH CARE *(other than your visits to the pain clinic)*

1.	How many times in the past 3 months have you seen a general practitioner in regard to your pain?	_____times
2.	How many times in the past 3 months have you seen a medical specialist (e.g. orthopaedic surgeon) in regard to your pain?	_____times
3.	How many times in the past 3 months have you seen health professionals other than doctors (e.g. physiotherapist, chiropractor, psychologist) in regard to your pain?	_____times
4.	How many times in the past 3 months have you visited a hospital emergency department in regard to your pain? (include all visits, regardless of whether or not you were admitted to hospital from the emergency department)	_____times
5.	How many times in the past 3 months have you been admitted to hospital as an inpatient because of your pain?	_____times
6.	How many diagnostic tests (e.g. x-rays, scans) have you had in the last 3 months relating to your pain?	_____times

SECTION 2: YOUR WORK

Are you currently employed (working for pay)?

☐ Yes – If yes, are you:
- ☐ Working full-time
- ☐ Working part-time

Please answer the questions below ↓

☐ No – If no, are you:

(Tick **one** only, then go straight to **Section 3**)
- ☐ Unable to work due to a condition other than pain
- ☐ Unable to work due to pain
- ☐ Not working be choice (student, retired, homemaker)
- ☐ Seeking employment (I consider myself able to work but cannot find a job)

During the past seven days, how many hours did you miss from work because of problems associated with your pain?

(Include hours you missed on sick days, times you went in late, left early etc. because of your pain. Do not include time you missed to attend this pain clinic). _____hours

During the past seven days, how many hours did you actually work?

*(If '0' skip the next question and go to **Section 3**)* _____hours

During the past seven days, how much did your pain affect your productivity while you were working?

- Think about days you were limited in the amount or kind of work you could do, days you accomplished less than you would like, or days you could not do your work as carefully as usual.
- Consider only how much pain affected productivity while you were working

If pain affected your work only a little, choose a low number.
0 = Pain had no effect on my work

Choose a high number if pain affected your work a great deal.
10= Pain Completely prevented me from working

0 1 2 3 4 5 6 7 8 9 10

CIRCLE ONE NUMBER

SECTION 3: YOUR MEDICATION/S

Are you taking any medications?

☐ No (please go to **Section 4)**

☐ Yes (Please list all the medications you are taking. Include both prescription and over-the-counter medicines)

Medication Name (as on label)	Medication Strength (as on label)	How many do you take per day?	How many days per week do you take this medication?

SECTION 4: PAIN INTENSITY AND INTERFERENCE

In the below table:

- Put a X in all of the areas where you feel pain.
- Circle the ONE area that hurts the most.

Body Region	Left	Right	Body Region	Left	Right
Head (excluding face)			Abdomen		
Face/Jaw/Temple			Hip		
Throat/Neck			Groin/Pubic Area		
Shoulder			Thigh		
Chest			Knee		
Upper Arm			Calf		
Elbow			Ankle		
Forearm			Foot		
Wrist			Upper Back		
Hand			Mid Back		
			Low Back		

Please rate your pain by circling the ONE number that best describes the following:

	0 = No pain										10 = Pain as bad as you can imagine
1. Your pain at its worst in the last week?	0	1	2	3	4	5	6	7	8	9	10
2. Your pain at its least in the last week?	0	1	2	3	4	5	6	7	8	9	10
3. Your pain on average?	0	1	2	3	4	5	6	7	8	9	10
4. How much pain do you have right now?	0	1	2	3	4	5	6	7	8	9	10

During the past week, how much has pain interfered with the following:

	0 = No interference										10 = Complete interference
1. Your general activity?	0	1	2	3	4	5	6	7	8	9	10
2. Your mood?	0	1	2	3	4	5	6	7	8	9	10
3. Your walking ability?	0	1	2	3	4	5	6	7	8	9	10
4. Your normal work (both outside home and housework)?	0	1	2	3	4	5	6	7	8	9	10
5. Your relations with other people?	0	1	2	3	4	5	6	7	8	9	10
6. Your sleep?	0	1	2	3	4	5	6	7	8	9	10
7. Your enjoyment of life?	0	1	2	3	4	5	6	7	8	9	10

EPMP (OFFICE USE)	
Pain severity score:	Pain interference score:

SECTION 5: DASS21

Please read each statement and circle 0, 1, 2 or 3 which indicates how much the statement applies to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all – **Not at all**
1 Applied to me to some degree, or some of the time – **Some of the time**
2 Applied to me to a considerable degree, or a good part of time – **A good part of the time**
3 Applied to me very much, or most of the time – **Most of the time**

Please rate your pain by circling the ONE number that best describes the following:

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

EPMP (OFFICE USE)			
DASS21 total score:	Depression score:	Anxiety score:	Stress score:

SECTION 6: PSEQ

Rate how confident you are that you can do the following things at present despite the pain. Circle one of the numbers on the sale under each item, where 0 = *Not confident at all* and 6 = *Completely confident*.

Remember the 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**.

Please rate your pain by circling the ONE number that best describes the following:

	0 = Not confident						6 = Completely confident
1. I can enjoy things, despite the pain	0	1	2	3	4	5	6
2. I can do most household chores (tidying up, washing dishes etc), despite the pain	0	1	2	3	4	5	6
3. I can socialise with my friends or family members as often as I used to, despite the pain	0	1	2	3	4	5	6
4. I can cope with my pain in most situations	0	1	2	3	4	5	6
5. I can do some form of work, despite the pain ("work" includes housework, pain and unpaid work)	0	1	2	3	4	5	6
6. I can still do many of the things I enjoy doing, such as hobbies or leisure activity, despite the pain	0	1	2	3	4	5	6
7. I can cope with my pain without medication	0	1	2	3	4	5	6
8. I can still accomplish most of my goals in life, despite the pain	0	1	2	3	4	5	6
9. I can live a normal lifestyle, despite the pain	0	1	2	3	4	5	6
10. I can generally become more active, despite the pain	0	1	2	3	4	5	6

EPMP (OFFICE USE)

Total score:

SECTION 7: PCS

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 thirteen statements describing thoughts and feelings that may be associated with pain. Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

0 Not at all
1 To a slight degree
2 To a moderate degree
3 To a great degree
4 All the time

Please rate your pain by circling the ONE number that best describes the following:

	0 = Not at all				4 = All the time
1. I worry all the time about whether the pain will end	0	1	2	3	4
2. I feel I can't go on	0	1	2	3	4
3. It's terrible and I think it's never going to get any better	0	1	2	3	4
4. It's awful and I feel it overwhelms me	0	1	2	3	4
5. I feel I can't stand it anymore	0	1	2	3	4
6. I become afraid that the pain will get worse	0	1	2	3	4
7. I keep thinking of other painful events	0	1	2	3	4
8. I anxiously want the pain to go away	0	1	2	3	4
9. I can't seem to keep it out of my mind	0	1	2	3	4
10. I keep thinking about how much it hurts	0	1	2	3	4
11. I keep thinking about how badly I want the pain to stop	0	1	2	3	4
12. There's nothing I can do to reduce the intensity of the pain	0	1	2	3	4
13. I wonder whether something serious may happen	0	1	2	3	4

Thank you for your time completing this questionnaire.

EPMP (OFFICE USE)

PCS total score:	Helplessness score:	Rumination score:	Magnification score: