

Appendix IV (i)

SHORT FORM MCGILL PAIN QUESTIONNAIRE and PAIN DIAGRAM

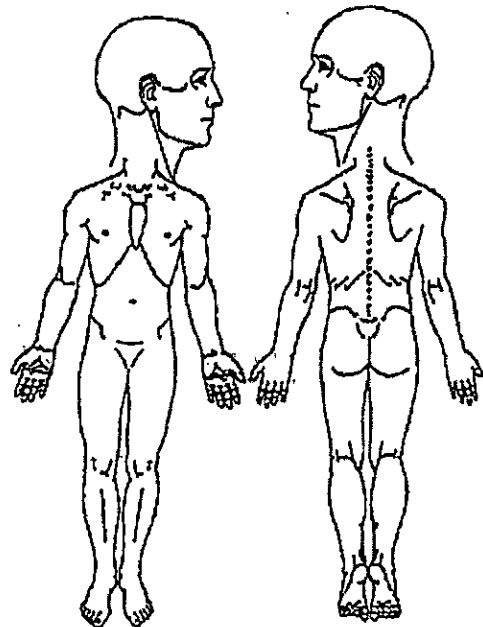
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Date: _____

Name: _____

Check the column to indicate the level of your pain for each word, or leave blank if it does not apply to you. _____

	Mild	Moderate	Severe
1 Throbbing	_____	_____	_____
2 Shooting	_____	_____	_____
3 Stabbing	_____	_____	_____
4 Sharp	_____	_____	_____
5 Cramping	_____	_____	_____
6 Gnawing	_____	_____	_____
7 Hot-burning	_____	_____	_____
8 Aching	_____	_____	_____
9 Heavy	_____	_____	_____
10 Tender	_____	_____	_____
11 Splitting	_____	_____	_____
12 Tiring-Exhausting	_____	_____	_____
13 Sickening	_____	_____	_____
14 Fearful	_____	_____	_____
15 Cruel-Punishing	_____	_____	_____



Mark or comment on the above figure where you have your pain or problems.

Indicate on this line how bad your pain is—at the left end of line means no pain at all, at right end means worst pain possible.

No Pain _____ Worst Possible Pain

S /33 A /12 VAS /10

PROGRESS NOTE

Pain Assessment and Documentation Tool (PADT™)

Patient Stamp Here

Patient Name: _____ Record #: _____

Assessment Date: _____

Current Analgesic Regimen

Drug name	Strength (eg. mg)	Frequency	Maximum Total Daily Dose

The PADT is a clinician-directed interview; that is, the clinician asks the questions, and the clinician records the responses. The Analgesia, Activities of Daily Living, and Adverse Events sections may be completed by the physician, nurse practitioner, physician assistant, or nurse. The Potential Aberrant Drug-Related Behavior and Assessment sections must be completed by the physician. Ask the patient the questions below, except as noted.

Analgesia

If zero indicates "no pain" and ten indicates "pain as bad as it can be," on a scale of 0 to 10, what is your level of pain for the following questions?

1. What was your pain level on average during the past week? (please circle the appropriate number)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

2. What was your pain level at its worst during the past week?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

3. What percentage of your pain has been relieved during the past week? (Write in a percentage between 0% and 100%.)

4. Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference in your life?
 Yes No

5. Query to clinician: Is the patient's pain relief clinically significant?
 Yes No Unsure

Activities of Daily Living

Please indicate whether the patient's functioning with the current pain reliever(s) is Better, the Same, or Worse since the patient's last assessment with the PADT.* (Please check the box for Better, Same, or Worse for each item below.)

	Better	Same	Worse
1. Physical Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Family relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Social relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Sleep patterns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Overall functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* If the patient is receiving his or her first PADT assessment, the clinician should compare the patient's functional status with other reports from the last office visit.

(Continued on reverse side)

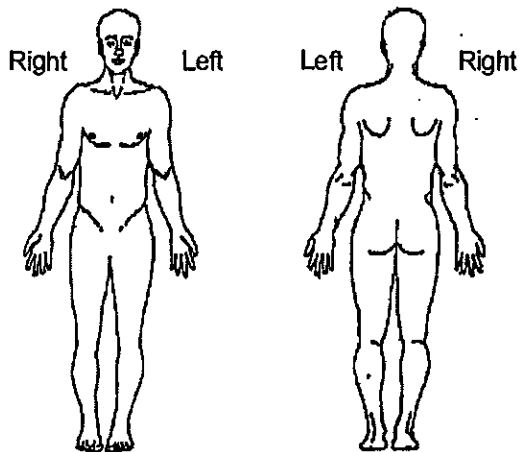
BRIEF PAIN INVENTORY

Date _____ / _____ / _____ Time: _____

Name: _____
LAST FIRST MIDDLE INITIAL

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?
 1. Yes 2. No

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



3) Please rate your pain by circling the one 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 as bad as you can imagine

4) Please rate your pain by circling the one 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 as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**.

0 1 2 3 4 5 6 7 8 9 10
 No Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have **RIGHT NOW**.

0 1 2 3 4 5 6 7 8 9 10
 No Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

8) In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much **RELIEF** you have received.

0% 10 20 30 40 50 60 70 80 90 100%
 No relief Complete relief

9) Circle the one 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

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
 Does not Interfere Completely Interferes

In addition to completing the Brief Pain Inventory, to help your doctor better manage your pain, please tell us:

What does the pain feel like? Circle those words that describe your pain.

aching	throbbing	shooting
stabbing	gnawing	prickling
sharp	tender	burning
exhausting	tiring	penetrating
nagging	numb	miserable
unbearable	dull	radiating
squeezing	cramping	deep

How long have you had this pain? (Circle one)

less than a week	1 to 2 weeks
2 to 4 weeks	more than a month

What kinds of things make your pain feel better (for example, heat, medicine, rest)?

What kinds of things make your pain worse (for example, walking, standing, lifting)?

Do you have any other symptoms? Circle any that apply:

nausea	vomiting
constipation	diarrhea
lack of appetite	indigestion
difficulty sleeping	feeling drowsy
nightmares	dizziness
tiredness	itching
urinary problems	sweating
weakness	headaches

Talking About Your Pain

It's important to remember that each person's pain is different. The pain that you experience can't be compared to another person's pain. ONLY YOU know how and when your hurt, and how the pain effects your life.

It is important to describe what you are feeling to those who are trained to help you. Don't be embarrassed to talk to your doctor, nurse, or pharmacist. They need to know as much as possible about your pain in order to develop the best plan to control it. The questions on this form can help you describe your pain.

Why Is Pain Relief So Important

Proper treatment for pain is not only a matter of comfort. Unrelieved pain can lead to nausea, loss of sleep, depression, loss of appetite, weakness, and other problems. Pain can also affect your life at home and at work. Relieving your pain means that you can continue to do the day-to-day things that are important to you.

Most Pain Can Be Controlled

It is important to know that most pain CAN be relieved. Your doctor will work with you to find the treatment that may be best for your pain.

The key to effective pain control is to take the RIGHT AMOUNT, of the RIGHT MEDICINE, at the RIGHT TIME. You should take your pain medicine on a regular schedule, as your doctor, nurse, or pharmacist tells you. Don't wait until the pain becomes severe. Pain is easier to control when it is mild than when it has reached full force.

If your pain medicine wears off too soon, is not relieving the pain, or causes problems with side effects, you should call your doctor because you may need to have your treatment plan changed.

Comments: Write down any questions or information you need to share with your doctor, nurse, or pharmacist about your pain.
