Patient Name: _____ Date: _____ / _____ / _____

PATIENT INFORMATION BOOKLET

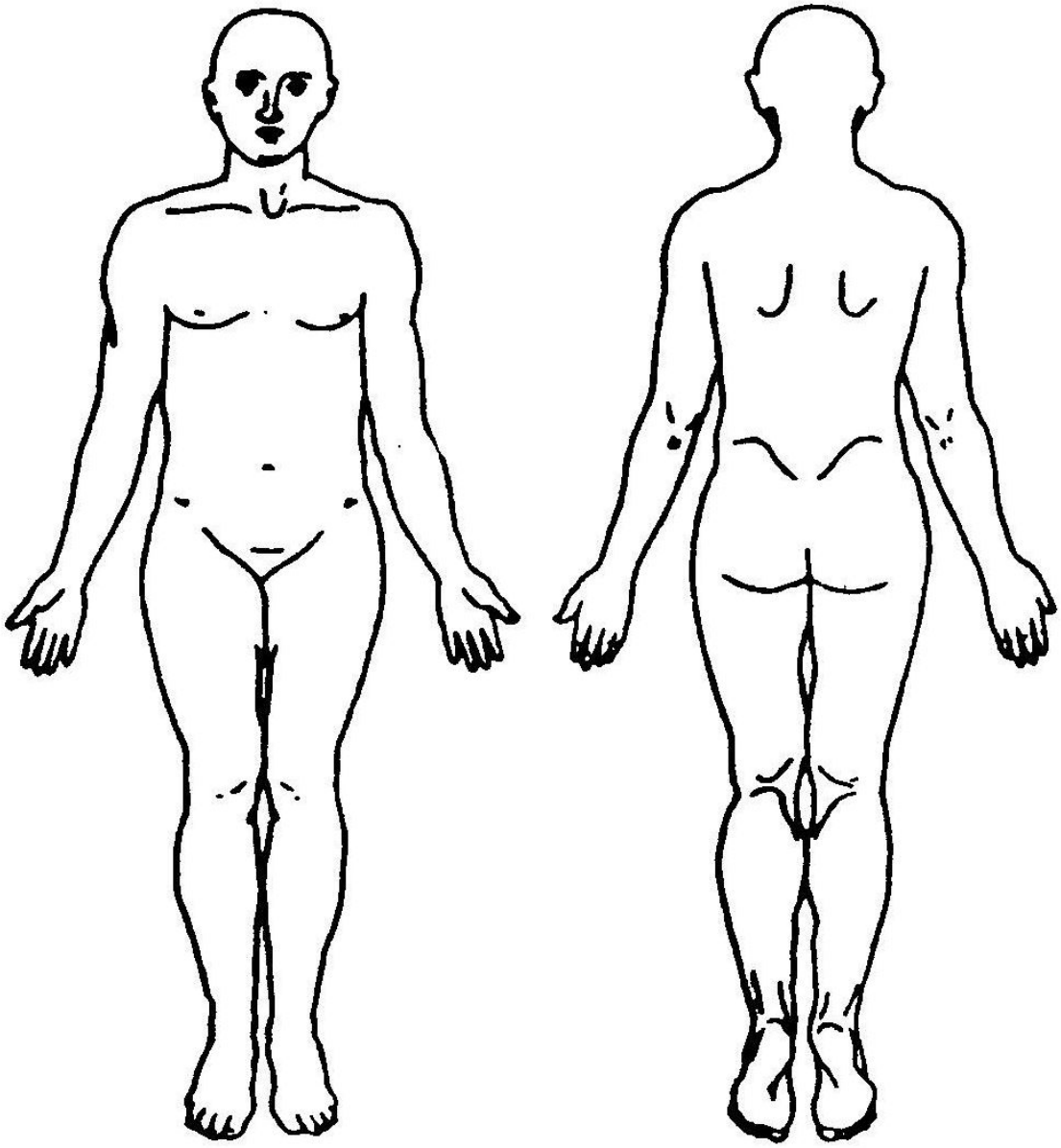
Instructions:

- ⇨ The following pages contain a number of questions that relate to how **your** pain impacts on **your** life.
- ⇨ Your answers will allow us to appreciate the consequences of your pain on your overall well-being.
- ⇨ Answer each question honestly as these answers will assist the Doctor to fully assess your individual situation.
- ⇨ You may answer the questions in one sitting or you may take breaks in between sections to avoid survey fatigue.
- ⇨ Please ensure your name is written on every page.
- ⇨ **Please complete and return pages 2 – 15 prior to your appointment.**

Patient Name: _____ Date: _____ / _____ / _____

Please mark as accurately as you can,

1 to 2 areas of your body where you feel the most pain.



Patient Name: _____ Date: _____ / _____ / _____

BRIEF PAIN INVENTORY

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?
   ☐ Yes ☐ No

2. Please rate your pain by circling the one number that describes your pain at its **WORST** in the last 24 hours.

1 2 3 4 5 6 7 8 9 10
No Pain — Worst Pain Imaginable

3. Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the last 24 hours.

1 2 3 4 5 6 7 8 9 10
No Pain — Worst Pain Imaginable

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

1 2 3 4 5 6 7 8 9 10
No Pain — Worst Pain Imaginable

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

1 2 3 4 5 6 7 8 9 10
No Pain — Worst Pain Imaginable

6. What treatments or medications are you receiving for your pain?

_____

_____

7. 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.

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
No Relief — Complete Relief

8. Circle the one number that describes how, during the past 24 hours, pain has **INTERFERED** with your:

A. General Activity

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

B. Mood

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

C. Walking ability

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)

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

E. Relations with other people

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

F. Sleep

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

G. Enjoyment of life

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

Office Use Only	**Pain Severity** Score: _____
	Pain Interference Score: _____

Please tick ☐ if you do not give authority for your information and history to be used for research purposes.
If your information is studied, your name will be de-identified, which means your name will be held and not released.

Patient Name: _____ Date: _____ / _____ / _____

ACTIVITY

Please rate how confident you are of the following things **at present**, despite the pain. To indicate your answer, **circle one** of the numbers on the scale under each item.

0 = not confident at all **6** = completely confident

1. I can still enjoy things, despite the pain

0	1	2	3	4	5	6
Not confident at all						Completely confident

2. I can do most of the household chores (eg. tidying up, washing dishes, etc), despite the pain

0	1	2	3	4	5	6
Not confident at all						Completely confident

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
Not confident at all						Completely confident

4. I can cope with my pain in most situations

0	1	2	3	4	5	6
Not confident at all						Completely confident

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
Not confident at all						Completely confident

ACTIVITY continues on following page

Patient Name: _____ Date: _____ / _____ / _____

ACTIVITY (continued)
Please rate how confident you are of the following things at present, despite the pain. To indicate your answer, **circle one** of the numbers on the scale under each item, where

0 = not confident at all **6** = completely confident

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
Not confident at all						Completely confident

7. I can cope without pain medication

0	1	2	3	4	5	6
Not confident at all						Completely confident

8. I can still accomplish most of my goals in life, despite the pain

0	1	2	3	4	5	6
Not confident at all						Completely confident

9. I can live a normal lifestyle, despite the pain

0	1	2	3	4	5	6
Not confident at all						Completely confident

10. I can gradually become more active, despite the pain

0	1	2	3	4	5	6
Not confident at all						Completely confident

ACTIVITY ends, please continue to **CONCERNS**

Office Use Only | **ACTIVITY** Total: _____

Patient Name: _____ Date: _____ / _____ / _____

CONCERNS

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

Rating	**0**	**1**	**2**	**3**	**4**
Meaning	not at all	to a slightest degree	to a moderate degree	to a great degree	all the time

When I'm in pain:

No.	**Statement**	**Rating**
1	I worry all the time about whether the pain will end	
2	I feel I can't go on	
3	It's terrible and I think it's never going to get any better	
4	It's awful and I feel that it overwhelms me	
5	I feel I can't stand it anymore	
6	I become afraid that the pain will get worse	
7	I keep thinking of other painful events	
8	I anxiously want the pain to go away	
9	I can't seem to keep it out of my mind	
10	I keep thinking about how much it hurts	
11	I keep thinking about how badly I want the pain to stop	
12	There's nothing I can do to reduce the intensity of pain	
13	I wonder whether there's something serious may happen	

CONCERNS ends, please continue to **THOUGHTS**

Office Use Only | **CONCERNS** Total: _____

Patient Name: _____ Date: _____ / _____ / _____

THOUGHTS

In these days of high-tech medicine, one of the most important sources of information about you is often missing from your medical records, which is **your own feelings** or intuitions about what is happening with your body. We hope that the following information will help to fill this gap.

Please rate each statement according to your own feelings, not what others suggest you should believe. This is not a test of medical knowledge; we want to know how you see it.

Circle the number next to each question that best corresponds to how you feel

The rating scale is as follows:
1 = strongly disagree **2** = somewhat disagree **3** = somewhat agree **4** = strongly agree

1.	I'm afraid that I might injure myself if I exercise	**1**	**2**	**3**	**4**
2.	If I were to try to overcome it, my pain would increase	**1**	**2**	**3**	**4**
3.	My body is telling me I have something dangerously wrong	**1**	**2**	**3**	**4**
4.	My pain would probably be relieved if I were to exercise	**1**	**2**	**3**	**4**
5.	People aren't taking my medical condition seriously enough	**1**	**2**	**3**	**4**
6.	My accident put me at risk for the rest of my life	**1**	**2**	**3**	**4**
7.	Pain always means I injured my body	**1**	**2**	**3**	**4**
8.	Just because something aggravates my pain does not mean it's dangerous	**1**	**2**	**3**	**4**
9.	I'm afraid that I might injure myself accidentally	**1**	**2**	**3**	**4**
10.	Simply being careful, that I do not make any unnecessary movements is the safest thing I can do to prevent my pain from worsening	**1**	**2**	**3**	**4**
11.	I wouldn't have this much pain if there wasn't something potentially dangerous going on in my body	**1**	**2**	**3**	**4**

THOUGHTS continues on following page

Patient Name: _____ Date: _____ / _____ / _____

Please rate each statement according to your own feelings, not what others suggest you should believe. This is not a test of medical knowledge; we want to know how you see it.

Circle the number next to each question that best corresponds to how you feel

The rating scale is as follows:

1 = strongly disagree **2** = somewhat disagree **3** = somewhat agree **4** = strongly agree

---

12.	Although my pain condition is painful, I would be better off if I were physically active	**1**	**2**	**3**	**4**
13.	Pain lets me know when to stop exercising so that I don't injure myself	**1**	**2**	**3**	**4**
14.	It's really not safe for a person with a condition like mine to be physically active	**1**	**2**	**3**	**4**
15.	I can't do all the things normal people do because it's too easy for me to get injured	**1**	**2**	**3**	**4**
16.	Even though something is causing me a lot of pain, I don't think it is actually dangerous	**1**	**2**	**3**	**4**
17.	No one should have to exercise when he/she is in pain	**1**	**2**	**3**	**4**

THOUGHTS ends, please continue to **DASS21**

Office Use Only | **THOUGHTS** Total: _____

Patient Name: _____ Date: _____ / _____ / _____

DASS21

Please read each statement and circle a number 0, 1, 2, or 3 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 any statement.

The rating scale is as follows:

0 = Did not apply to me at all – **N**EVER
1 = Applied to me to some degree, or some of the time – **S**OMETIMES
2 = Applied to me to a considerable degree, or a good part of the time – **O**FTEN
3 = Applied to me very much, or most of the time – **A**LMOST **A**LWAYS

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		N	S	O	AA	D	A	S
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 overreact 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. a 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			
					TOTALS			
					x 2	D	A	S

Patient Name: _____ Date: _____ / _____ / _____

Oswestry Disability Index (ODI) ver. 2.1a

This questionnaire is designed to give us information about how your back (or leg) trouble affects your ability to manage in everyday life. Please answer every section. Mark **one box only** in each section that most closely describes you today.

Section 1 - Pain intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 - Personal care (washing, dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally, but it is very painful.
- ☐ It is painful to look after myself, and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and I stay in bed.

Section 3 - Lifting

- ☐ I can lift heavy objects without extra pain.
- ☐ I can lift heavy objects, but it causes extra pain.
- ☐ Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy objects, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light objects.
- ☐ I cannot lift or carry anything at all.

Section 4 - Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one kilometre.
- ☐ Pain prevents me from walking more than 500 metres.
- ☐ Pain prevents me from walking more than 100 metres.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favourite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than half an hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Patient Name: _____ Date: _____ / _____ / _____

Section 6 - Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want, but it causes me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than half an hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 - Sleeping

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ I have less than 6 hours sleep because of pain.
- ☐ I have less than 4 hours sleep because of pain.
- ☐ I have less than 2 hours sleep because of pain.
- ☐ I cannot sleep at all because of pain.

Section 8 - Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

Section 9 - Social life

- ☐ My social life is normal and causes me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
- ☐ Pain has restricted my social life, and I do not go out as often.
- ☐ Pain has restricted social life to my home.
- ☐ I have no social life because of pain.

Section 10 - Travelling

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere, but it causes extra pain.
- ☐ Pain is bad, but I manage journeys over two hours.
- ☐ Pain restricts me to journeys of less than one hour.
- ☐ Pain restricts me to short, necessary journeys under 30 minutes.
- ☐ Pain prevents me from travelling except to receive treatment.

Office Use Only | **ODI** Score: _____ %

Patient Name: _____ Date: _____ / _____ / _____

HEALTH CARE ACCESS

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 the hospital from the emergency department.	_____ times
5	How many times in the past 3 months have you been admitted to hospitals 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

Patient Name: _____ Date: _____ / _____ / _____

MEDICATION & INFORMATION FORM

List **ALL** medication that you are currently taking	Dose	Number of Times per day

List **previous** medications that you have tried	Was it effective?
	Yes ☐ No ☐
	Yes ☐ No ☐
	Yes ☐ No ☐
	Yes ☐ No ☐
	Yes ☐ No ☐
	Yes ☐ No ☐

Tick previous treatments that you have tried	Was it effective?	Is it ongoing?
☐ Physiotherapy	Yes ☐ No ☐	Yes ☐ No ☐
☐ Chiropractic	Yes ☐ No ☐	Yes ☐ No ☐
☐ Hydrotherapy	Yes ☐ No ☐	Yes ☐ No ☐
☐ TENS Machine	Yes ☐ No ☐	Yes ☐ No ☐
☐ Acupuncture	Yes ☐ No ☐	Yes ☐ No ☐
☐ Massage	Yes ☐ No ☐	Yes ☐ No ☐
☐ Other	Yes ☐ No ☐	Yes ☐ No ☐
	Yes ☐ No ☐	Yes ☐ No ☐
	Yes ☐ No ☐	Yes ☐ No ☐
	Yes ☐ No ☐	Yes ☐ No ☐
	Yes ☐ No ☐	Yes ☐ No ☐

List any allergies
.....
.....

Patient Name: _____ Date: _____ / _____ / _____

MEDICATION & INFORMATION FORM (continued)

Do you drink alcohol?	Yes ☐ No ☐
How many standard drinks per day? Glass of Wine = 1.5 Nip of Spirits = 1 400mls mid/light Beer = 1.0 400mls full strength Beer = 1.5 *(ref: www.alcohol.gov.au)*	
Smoking Classification	Never ☐ Ex-Smoker ☐ Smoker ☐
If a Smoker, how long since you started smoking?	
If an Ex-Smoker, how long since you stopped smoking?	
If a Smoker or an Ex-Smoker, how many cigarettes per day?	_____ cigarettes/day _____ pipe/day _____ cigars/day
How many hours of sleep per night on average?	
Is this sleep broken by pain?	Yes ☐ No ☐
Do you wake with pain?	Yes ☐ No ☐
What is your job or trade?	
Are you currently working?	Yes ☐ No ☐
If not, when did you cease work?	
How many hours per week do you work?	
Has a Compensation Claim been initiated?	Yes ☐ No ☐

Patient Name: _____ Date: _____ / _____ / _____

CONSENT TO USE INFORMATION

Associated with your treatment at Sydney Spine & Pain Clinic, personal details and medical information will be collected. The Australian Privacy Principles dictate that we require your consent to use your personal information. We use your personal information for the reasons outlined below:

► To facilitate data collection and reporting of outcomes which may be used for quality improvement, development of service delivery, and planning at the Sydney Spine and Pain Clinic.

► To inform your next of kin or authorised representative whom you have nominated, of the outcome of treatment, for example, an enduring power of attorney, guardian or carer.

► To enable us to provide information to authorities such as Medicare, Veterans Affairs, health funds, Commonwealth and state departments, as well as inform Third Party certification bodies who may audit against compliance to the Privacy Principles.

► To inform other medical practitioners or institutions who may treat you in the future, but only to the extent necessary to treat the particular condition. This may include the exchange of information, for example, previous test results.

► To assist in providing practical training and education to medical, nursing or allied health professionals, such as physiotherapists and rehabilitation specialists.

► To provide your contact information to Australian Medical Research (AMR) and be informed of upcoming clinical research studies that you may be suitable to participate in. AMR is associated with Sydney Spine & Pain Clinic and manages clinical trials for new medications, techniques and devices.

☐ Please tick if you do not give consent for your contact information to be included in the database.

► To provide AMR with your de-identified clinical data for research purposes. You will not be identified in any research publications that result from this.

☐ Please tick if you do not give consent for your de-identified information to be used for research purposes.

NOTE: If you do not understand anything in this document or have any questions, please do not sign until you have had your questions answered to your satisfaction.

Please refer to the Privacy Policy displayed at Reception for further Information regarding privacy.

_____	_____	_____
Name (Please Print)	Signature	Date