

Name	Phone number
Address	
GP	

NHI:

1. What is the type of pain problem? (describe:.....*or use list under:*)
- | | | | | | |
|---|--------------------------------------|---------------------------------|--|---------------------------------|--------------------------------------|
| <input type="checkbox"/> Head/Neck | <input type="checkbox"/> Upper Limbs | <input type="checkbox"/> Thorax | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Pelvis | <input type="checkbox"/> Lower Limbs |
| <input type="checkbox"/> Cancer related | | | <input type="checkbox"/> Non-cancer | | |
| <input type="checkbox"/> Localised | | | <input type="checkbox"/> Widespread / multiple sites | | |
| <input type="checkbox"/> Cervical spine | | | <input type="checkbox"/> Oro-facial / dental | | |
| <input type="checkbox"/> Back pain | | | <input type="checkbox"/> Back + lower limb radiation | | |
| <input type="checkbox"/> Musculoskeletal | | | <input type="checkbox"/> Nerve injury / damage | | |
| <input type="checkbox"/> Zoster / Post Herpetic Neuralgia | | | <input type="checkbox"/> Post-stroke / central pain | | |

2. How long, ie. number, has THIS pain problem existed? Years, or Months

3. Did this pain start following a medical / surgical procedure? No Yes
 What procedure? When?

4. ... or some other significant event? When?
 What was it?

5. Is / was the patient:
- | | currently | 1 year ago | |
|--|--------------------------|--------------------------|-----------------|
| a. in paid employment | <input type="checkbox"/> | <input type="checkbox"/> | work type |
| b. primarily a homemaker | <input type="checkbox"/> | <input type="checkbox"/> | |
| c. main caregiver of dependants | <input type="checkbox"/> | <input type="checkbox"/> | |
| d. studyingpart time <input type="checkbox"/> full time | <input type="checkbox"/> | <input type="checkbox"/> | |
| a. doing volunteer work | <input type="checkbox"/> | <input type="checkbox"/> | |
| b. retired | <input type="checkbox"/> | <input type="checkbox"/> | |
| c. on <input type="checkbox"/> ACC <input type="checkbox"/> SB <input type="checkbox"/> IB <input type="checkbox"/> DPB <input type="checkbox"/> UB: | <input type="checkbox"/> | <input type="checkbox"/> | |

Comment if you wish

7. In terms of **the patient's usual activities**, what impact does the PAIN have on function?
 no change
 mild change
 significant / major change

7. Has patient been seen at a specialised Pain Management service before? Yes No
 For this problem? Where? When?
 Other Problem? What was it? When?

8. Does the patient exhibit symptoms of anxiety depression stress non-coping?

9. Treatments tried past / present:
- Anticonvulsants or Antiarrhythmics (specifyduration.....)
 - Tricyclic "antidepressant" (which?duration.....)
 - Sympatholytic blocks: Guanethidine Stellate Ganglion
 - Trigger point injections
 - Opioids (specifyduration.....)
 - Physical reactivation
 - Cognitive methods and/or Relaxation program
 - TENs, Acupuncture
 - Other