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## Pain Outcomes Questionnaire – VA/S/INPT: Time 2

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**Patient:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

1.) Enter today's date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM/DD/YY)

2a.) On a scale of 0 to 10, with 0 being no pain at all and 10 being the worst possible pain, how would you rate your pain on the **AVERAGE** during the **LAST WEEK**?

0	1	2	3	4	5	6	7	8	9	10
no pain at all										worst possible pain

2b.) On a scale of 0 to 10, what was your **LOWEST LEVEL OF PAIN** during the **LAST WEEK**?

0	1	2	3	4	5	6	7	8	9	10
no pain at all										worst possible pain

2c.) On a scale of 0 to 10, what was your **HIGHEST LEVEL OF PAIN** during the **LAST WEEK**?

0	1	2	3	4	5	6	7	8	9	10
no pain at all										worst possible pain

3.) No one has pain as bad as mine.

0	1	2	3	4	5	6	7	8	9	10
totally disagree										totally agree

4.) It seems like every day a new part of my body hurts.

0	1	2	3	4	5	6	7	8	9	10
totally disagree										totally agree

5.) Does your pain interfere with your ability to walk?

0	1	2	3	4	5	6	7	8	9	10
not at all										all the time

6.) Does your pain interfere with your ability to carry/handle everyday objects such as a bag of groceries or books?

0 1 2 3 4 5 6 7 8 9 10  
not at all all the time

7.) Walking even a few feet causes my pain to become unbearable.

0 1 2 3 4 5 6 7 8 9 10  
totally disagree totally agree

8.) Does your pain interfere with your ability to climb stairs?

0 1 2 3 4 5 6 7 8 9 10  
not at all all the time

9.) Does your pain require you to use a cane, walker, wheelchair or other devices?

0 1 2 3 4 5 6 7 8 9 10  
not at all all the time

10.) When I move any part of my body my pain gets much worse.

0 1 2 3 4 5 6 7 8 9 10  
totally disagree totally agree

11.) Does your pain interfere with your ability to bathe yourself?

0 1 2 3 4 5 6 7 8 9 10  
not at all all the time

12.) Does your pain interfere with your ability to dress yourself?

0 1 2 3 4 5 6 7 8 9 10  
not at all all the time

13.) Does your pain interfere with your ability to use the bathroom?

0 1 2 3 4 5 6 7 8 9 10  
not at all all the time

14.) Does your pain interfere with your ability to manage your personal grooming (for example, combing your hair, brushing your teeth, etc.)?

0 1 2 3 4 5 6 7 8 9 10  
not at all all the time

15.) My chronic pain prevents me from sleeping more than two hours a night.

0 1 2 3 4 5 6 7 8 9 10  
totally disagree totally agree

16.) Does your pain affect your self-esteem or self-worth?

0 1 2 3 4 5 6 7 8 9 10  
not at all all the time

17.) My pain is worse than the pain others with my condition experience.

0 1 2 3 4 5 6 7 8 9 10  
totally disagree totally agree

18.) How would you rate your physical activity?

0 1 2 3 4 5 6 7 8 9 10  
significant limitation in basic activities can perform vigorous activities without limitation

19.) How would you rate your overall energy?

0 1 2 3 4 5 6 7 8 9 10  
totally worn out most energy ever

20.) My chronic pain prevents me from doing anything that I enjoy.

0 1 2 3 4 5 6 7 8 9 10  
totally disagree totally agree

21.) How would you rate your strength and endurance **TODAY**?

0 1 2 3 4 5 6 7 8 9 10  
very poor strength and endurance very high strength and endurance

22.) How would you rate your feelings of depression **TODAY**?

0 1 2 3 4 5 6 7 8 9 10  
not depressed at all extremely depressed

23.) How would you rate your feelings of anxiety **TODAY**?

0 1 2 3 4 5 6 7 8 9 10  
not anxious at all extremely anxious

24.) I can not imagine experiencing anything that hurts more than the chronic pain I experience every day.

0 1 2 3 4 5 6 7 8 9 10  
totally disagree totally agree

25.) How much do you worry about re-injuring yourself if you are more active?

0 1 2 3 4 5 6 7 8 9 10  
not at all all the time

26.) How safe do you think it is for you to exercise?

0 1 2 3 4 5 6 7 8 9 10  
not safe at all extremely safe

27.) Do you have problems concentrating on things **TODAY**?

0 1 2 3 4 5 6 7 8 9 10  
not at all all the time

28.) Every time one of my pain problems improves another one starts or gets worse.

0 1 2 3 4 5 6 7 8 9 10  
totally disagree totally agree

29.) How often do you feel tense?

0 1 2 3 4 5 6 7 8 9 10  
not at all all the time

30.) My pain never gets better.

0 1 2 3 4 5 6 7 8 9 10  
totally disagree totally agree

31.) How satisfied were you with the overall treatment you received?

0 1 2 3 4 5 6 7 8 9 10  
no satisfaction complete satisfaction

32.) How satisfied were you with staff warmth, respect, kindness, and willingness to listen?

0 1 2 3 4 5 6 7 8 9 10  
no satisfaction complete satisfaction

33.) How satisfied were you with the skills and competence of the staff?

0 1 2 3 4 5 6 7 8 9 10  
no satisfaction complete satisfaction

34.) How satisfied were you with the ease of getting appointments, hours of treatment, etc.?

0 1 2 3 4 5 6 7 8 9 10  
no satisfaction complete satisfaction

35.) Would you recommend this treatment to someone you know who has a pain problem?

0 1 2 3 4 5 6 7 8 9 10  
not recommended strongly recommended