Pain Outcomes Questionnaire – VA/S/INPT: Intake

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James A. Haley Veterans Affairs Hospital, Tampa, FL

**Patient: ___________________**  **Social Security #: ___________________**

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

2.) What is your age? _____

3.) Please indicate your sex:
   
   A) male   B) female

4.) Please indicate your race:
   
   A) African American   D) Asian
   B) White   E) American Indian
   C) Hispanic   F) Other

5.) What is your current marital status?
   
   A) never married   D) divorced or separated
   B) married   E) widowed
   C) living with someone but not married

6.) What is your current employment status?
   
   A) full-time employment   D) unemployed, looking for work
   B) part-time employment   E) unemployed, disabled
   C) unemployed, not interested   F) retired due to pain
   in returning to work   G) retired not due to pain

7.) How many years of education have you completed starting with the first grade?

   _____ Years

8.) Please select all of the following types of claims you have filed related to your pain problem:
   
   A) workers’ compensation
   B) personal injury (unrelated to work)
   C) Social Security Disability Insurance (SSDI)
   D) other insurance
   E) none
   F) VA Service Connection
9.) Are you currently involved in a formal legal suit related to your pain problem?

A) yes     B) no

10.) Please select all of the following pain locations that apply to you:

- A) leg
- B) low back
- C) mid-back
- D) upper back
- E) head
- F) neck
- G) shoulder
- H) buttocks
- I) foot
- J) jaw
- K) chest
- L) abdomen
- M) arm/hand
- N) fingers
- O) toes
- P) face
- Q) genitals
- R) other

11.) From the above pain sites, pick the **ONE** pain location that most interferes with your life:

- A) leg
- B) low back
- C) mid-back
- D) upper back
- E) head
- F) neck
- G) shoulder
- H) buttocks
- I) foot
- J) jaw
- K) chest
- L) abdomen
- M) arm/hand
- N) fingers
- O) toes
- P) face
- Q) genitals
- R) other

12a.) On a scale of 0 to 10, with 0 being no pain at all and 10 being the worst possible pain, what was your **AVERAGE 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

12b.) 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

12c.) 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

13.) On a scale of 0 to 10, what **AVERAGE LEVEL OF PAIN** is **ACCEPTABLE** to you:

0 1 2 3 4 5 6 7 8 9 10

- no pain
- at all
- worst possible
- pain
14.) How long have you had the pain for which you are now seeking treatment?

_____ Years  _____ Months

15.) Approximately how many NON-VA health care visits have you had in the LAST 3 MONTHS for your CURRENT PAIN PROBLEM? Include ALL visits to any NON-VA health care provider. For example, if you saw a surgeon once, a physical therapist 12 times, and a chiropractor 2 times for reasons related to your pain, the total number of visits would be 15.

Number of NON-VA health care visits: ______

16.) Approximately how many VA health care visits have you had in the LAST 3 MONTHS for your CURRENT PAIN PROBLEM? Include ALL visits to any VA health care provider. For example, if you saw a surgeon once, a physical therapist 12 times, and a chiropractor 2 times for reasons related to your pain, the total number of visits would be 15.

Number of VA health care visits: ______

17.) Please indicate any other physical illnesses or conditions you may have other than pain (indicate all that apply):

A) diabetes  D) heart disease  G) thyroid disease  J) other
B) lung disease  E) high blood pressure  H) liver disease  K) none
C) kidney disease  F) cancer  I ) seizures

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

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

19.) 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

20.) 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
21.) Does your pain interfere with your ability to carry/handle everyday objects such as a bag of groceries or books?

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

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

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

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

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

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

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

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

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30.) 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

31.) 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

32.) 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

33.) 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

34.) How would you rate your overall energy?
0 1 2 3 4 5 6 7 8 9 10
totally worn out
most energy ever

35.) 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

36.) 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

37.) How would you rate your feelings of depression TODAY?
0 1 2 3 4 5 6 7 8 9 10
not depressed
extremely depressed at all
38.) How would you rate your feelings of anxiety **TODAY**?

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

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

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

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

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

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44.) How often do you feel tense?

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45.) My pain never gets better.

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46.) Please indicate your VA Service Connection status:

   A) non-Service Connected
   B) non-Service Connected pension
   C) Service Connected

If you answered C) to question #46, **COMPLETE QUESTION #47**.

If you did NOT answer C) to question #46, **SKIP TO NEXT PAGE**.

47.) If you are Service Connected, what is your total percentage?

   ______ Percent

   **(PLEASE CONTINUE TO THE NEXT PAGE)**
48.) Do you have a disability claim of **ANY** type currently pending?

A) yes       B) no

49.) Are you currently using any opioid medications **ON A DAILY BASIS** (for example, Morphine, Oxycodone, Percocet, Hydrocodone, Vicodin, Oxycontin, Methadone, Buprenorphine, Suboxone, Dilaudid, Exalgo, Fentanyl patch, Tylenol #3 or #4, Tramadol)?

A) yes       B) no

If you answered **YES** to question #49, **COMPLETE QUESTIONS #50 & #51 ONLY.**

If you answered **NO** to question #49, **SKIP TO NEXT PAGE.**

50.) How long have you been using opioid medication **ON A DAILY BASIS** for your pain problem?

_____ Years       _____ Months

51.) Please rate the degree of pain relief you currently receive from these medications:

0 1 2 3 4 5 6 7 8 9 10

no relief complete relief

STOP HERE (If you answered **YES** to question #49)
52.) Have you used opioid medications **ON A DAILY BASIS DURING ANY PERIOD OF TIME** (for Morphine, Oxycodone, Percocet, Hydrocodone, Vicodin, Oxycontin, Methadone, Buprenorphine, Suboxone, Dilaudid, Exalgo, Fentanyl patch, Tylenol #3 or #4, Tramadol)?

   A) yes      B) no

If you answered **YES** to question #52, **PLEASE CONTINUE**.

If you answered **NO** to question #52, **STOP HERE**.

53.) How long has it been since you last used opioid medication **ON A DAILY BASIS**?

   _____ Years    _____ Months

54.) How long did you use opioid medication **ON A DAILY BASIS** for your pain problem?

   _____ Years    _____ Months

55.) Please rate the degree of pain relief you received from these medications:

   0  1  2  3  4  5  6  7  8  9  10  complete relief

   no relief