Adolescent Pain Questionnaire

Understanding your pain

This questionnaire is to help us learn about your pain. We want to understand your past pain so we can diagnose and treat you.

This questionnaire and any information given in interviews will remain confidential. If you do not wish to answer a question, write, "do not wish to answer" in the space provided.

Please print or write clearly.

Today's date: _______________ Your name:____

When did your present pain problem begin? Explain the symptoms, exact locations of pain.

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What was your reaction to the pain at that time? Please explain. ________________________________

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Were any major changes in your life occurring then? Please explain. ___________________________

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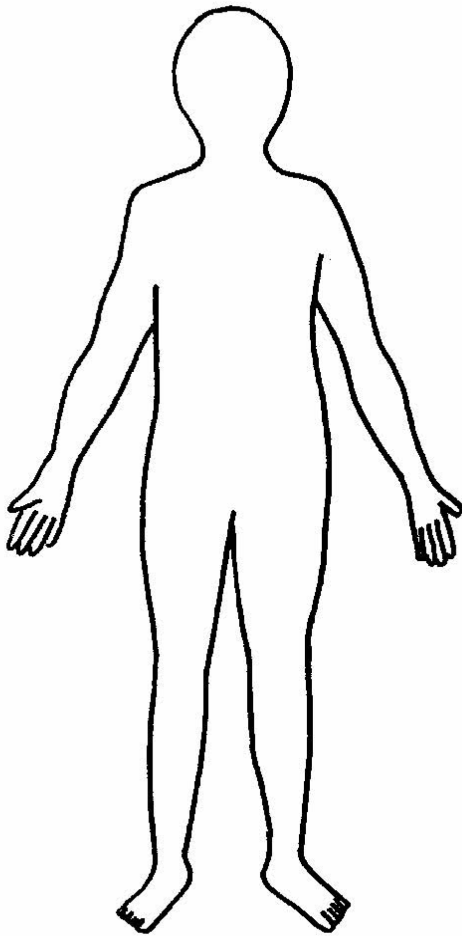
What do you call your pains? (For example, "headache," "joint pain," "stomachache," "backache," etc.) List them in order of severity, #1 being the most severe pain.

Pain problem #1: ____

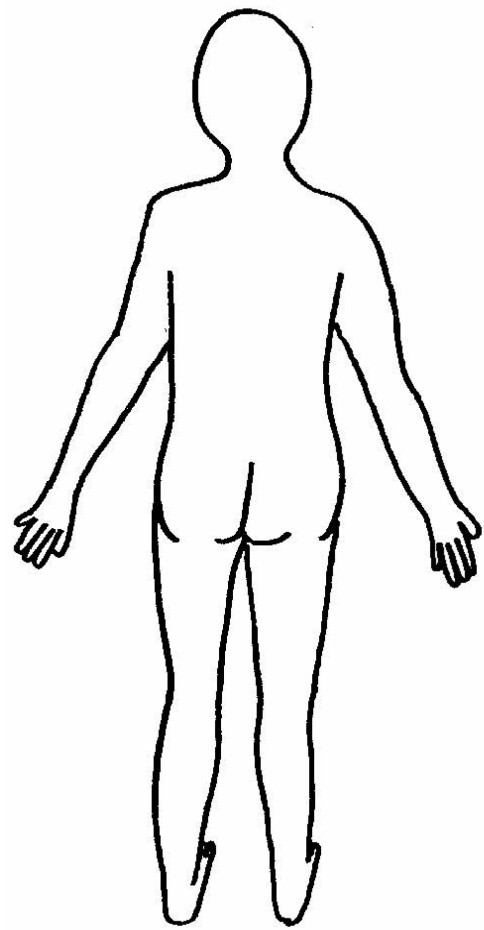
Pain problem #2: ____

Pain problem #3: ____

Mark an X on the exact place where you are having pain now. If there is more than one place, mark them “1,” “2,” “3”. Start with the most painful place as “1.”



Front



Back

Right side of head

Left side of head

My pain: ❑ is always there ❑ comes and goes ❑ is always there but sometimes gets worse

My pain is: ❑ staying the same ❑ getting worse ❑ getting better

Mark the words below that best describe your pain, or the way you feel when hurt or in pain.

❑ cutting	❑ pounding	❑ tingling	❑ tiring	❑ deep
❑ squeezing	❑ throbbing	❑ horrible	❑ stabbing	❑ burning
❑ pulling	❑ sickening	❑ biting	❑ screaming	❑ scraping
❑ aching	❑ uncomfortable	❑ cold	❑ miserable	❑ stretching
❑ pricking	❑ hot	❑ scared	❑ lonely	❑ jumping
❑ pinching	❑ unbearable	❑ sad	❑ itching	❑ grabbing
❑ stinging	❑ sharp	❑ sore	❑ flashing	❑ pins and needles

❑ Other: (describe) ____

Rate how much pain you have **right now** by placing a mark somewhere on the line.

Not hurting No discomfort No pain	______________________________________	Hurting a whole lot Very uncomfortable Severe pain

Rate how much pain you have **on an average** day by placing a mark somewhere on the line.

Not hurting No discomfort No pain	______________________________________	Hurting a whole lot Very uncomfortable Severe pain

Rate the **worst pain you had in the past week** (7 days) by placing a mark somewhere on the line.

Not hurting No discomfort No pain	______________________________________	Hurting a whole lot Very uncomfortable Severe pain

How many hours a day do you have pain now? ______________________________

How long does a single pain episode last? (minutes, hours) ______________________________

What time of the day do you have the most pain? ______________________________

What day of the week do you have the most pain? ______________________________

What week of the month do you have the most pain? ______________________________

What season or month do you have the most pain? ______________________________

Is your pain worse when you are: (please mark all that apply)

❑ tired ❑ angry ❑ upset ❑ anxious ❑ busy

❑ unhappy ❑ bored ❑ lonely ❑ arguing ❑ happy

❑ Other: (describe) ______________________________

Do you have any other symptoms with your pain? (please mark all that apply)

❑ stiffness ❑ swelling ❑ redness ❑ heat ❑ anxiety ❑ nausea

❑ vomiting ❑ dizziness ❑ fainting ❑ fast breathing ❑ fast heart rate ❑ sweating

❑ Other: (describe) ______________________________

Are you currently taking any medicine for pain? ❑ Yes ❑ No

If yes, complete the following information.

Medication	Dose	How often	How Effective 0 = not effective 10 = very effective

List any other medications you have tried in the past for your pain.

Medication	Dose	How often	How Effective 0 = not effective 10 = very effective

Other than medicine, what do you do to relieve your pain? ____________________________________

____

____

____

Does your pain keep you from doing any of the following? Circle the number that best describes how often.

	Never	Rarely	Sometimes	Often	Always
Enjoying the family	1	2	3	4	5
Eating/appetite	1	2	3	4	5
Sleeping	1	2	3	4	5
Seeing friends	1	2	3	4	5
Watching T.V.	1	2	3	4	5
Schoolwork	1	2	3	4	5
Attending school	1	2	3	4	5
Favorite activities	1	2	3	4	5
Other activities	1	2	3	4	5

Comments? ____

During the past three months, how often did your pain keep you from going to school?

- ❑ Never
- ❑ 1 day only
- ❑ 2-3 days
- ❑ 4-7 days
- ❑ more than 1 week
- ❑ more than 2 weeks
- ❑ more than 3 weeks
- ❑ more than 1 month

During the past three months, how often did your pain keep you from **vigorous** activities such as running, bicycling, lifting heavy objects, or participating in sports?

- ❑ Never
- ❑ 1 day only
- ❑ 2-3 days
- ❑ 4-7 days
- ❑ more than 1 week
- ❑ more than 2 weeks
- ❑ more than 3 weeks
- ❑ more than 1 month

During the past three months, how often did your pain keep you from **moderate** activities such as climbing several flights of stairs, bending, walking several blocks or lifting?

- ❑ Never
- ❑ 1 day only
- ❑ 2-3 days
- ❑ 4-7 days
- ❑ more than 1 week
- ❑ more than 2 weeks
- ❑ more than 3 weeks
- ❑ more than 1 month

During the past three months, how often did your pain keep you from **mild** activities such as walking one block, climbing one flight of stairs, sitting, or standing?

- ❑ Never
- ❑ 1 day only
- ❑ 2-3 days
- ❑ 4-7 days
- ❑ more than 1 week
- ❑ more than 2 weeks
- ❑ more than 3 weeks
- ❑ more than 1 month

If your pain were to be better managed, how would it change your life? ___________________________

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If the pain continues, what kinds of things do you think you should do? ___________________________

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Is there anything else you would like to tell us about your pain and the effect it has on you or your family?

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