



Parent Pain Questionnaire

Understanding your child's pain

This questionnaire is to help us learn about your child's pain problems. All information obtained from this questionnaire and in interviews will remain private. 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: _____ Your relationship to the child: _____

Child's name: _____ Date of birth: _____ Grade in school: _____

List the name, relationship, age and gender of everyone living in the home.

Name	Relationship	Age	Gender
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

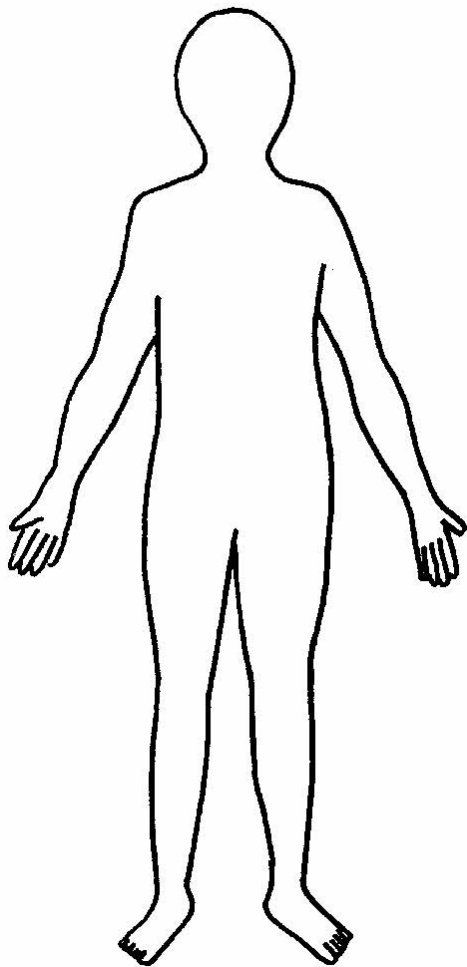
What do you call your child's pains? (For example, "headache," "joint pain," "stomachache," "backache," etc.) List them in order of severity, #1 being the most severe pain.

Pain Problem #1: _____

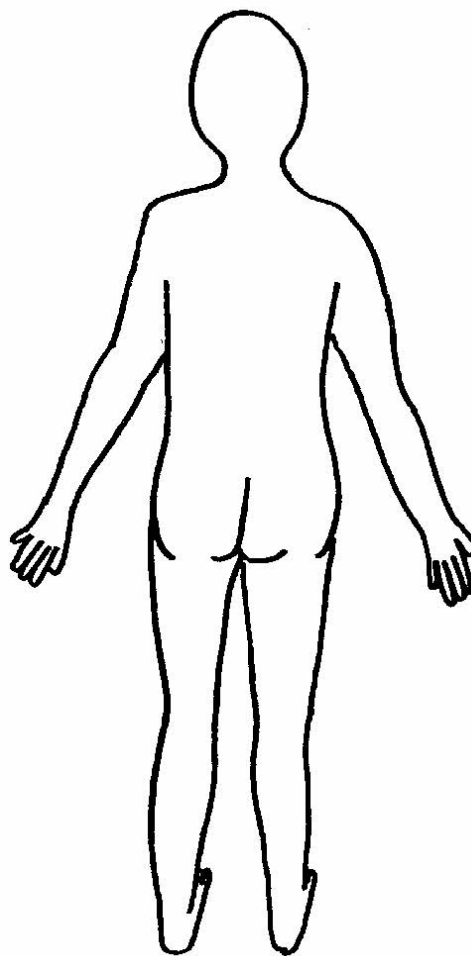
Pain Problem #2: _____

Pain Problem #3: _____

Mark an X on the exact place where you think your child is having pain now. If there is more than one painful place, mark them "1," "2," "3," etc. Start with the most painful place as "1."



Front



Back



Right side of head



Left side of head

How many hours a day does your child have pain now? _____

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

What time of the day does your child have the most pain? _____

What day of the week does your child have the most pain? _____

What week of the month does your child have the most pain? _____

What season or month does your child have the most pain? _____

Is your child's pain worse when they are: (please mark all that apply)

- tired angry upset anxious busy
 unhappy bored lonely arguing happy
 Other: (describe) _____

Does your child have any other symptoms with the pain? (please mark all that apply)

- stiffness swelling redness heat anxiety nausea
 vomiting dizziness fainting fast breathing fast heart rate sweating
 Other: (describe) _____

Is your child currently taking any medicine for pain? Yes No

If yes, complete the following information, indicating how effective.

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

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

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

List any other medications your child is currently taking.

Medication	Dose	How often	Reason

What do you currently do, besides giving medicine, to relieve your child's pain? _____

Does your child's pain interfere with any of these activities? Circle the number that best describes how often.

	<u>Never</u>	<u>Rarely</u>	<u>Sometimes</u>	<u>Often</u>	<u>Always</u>
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 of the school year, how often did your child's pain keep them from going to school?

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Never | <input type="checkbox"/> 4-7 days | <input type="checkbox"/> more than 3 weeks |
| <input type="checkbox"/> 1 day only | <input type="checkbox"/> more than 1 week | <input type="checkbox"/> more than 1 month |
| <input type="checkbox"/> 2-3 days | <input type="checkbox"/> more than 2 weeks | |

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

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Never | <input type="checkbox"/> 4-7 days | <input type="checkbox"/> more than 3 weeks |
| <input type="checkbox"/> 1 day only | <input type="checkbox"/> more than 1 week | <input type="checkbox"/> more than 1 month |
| <input type="checkbox"/> 2-3 days | <input type="checkbox"/> more than 2 weeks | |

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

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Never | <input type="checkbox"/> 4-7 days | <input type="checkbox"/> more than 3 weeks |
| <input type="checkbox"/> 1 day only | <input type="checkbox"/> more than 1 week | <input type="checkbox"/> more than 1 month |
| <input type="checkbox"/> 2-3 days | <input type="checkbox"/> more than 2 weeks | |

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

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Never | <input type="checkbox"/> 4-7 days | <input type="checkbox"/> more than 3 weeks |
| <input type="checkbox"/> 1 day only | <input type="checkbox"/> more than 1 week | <input type="checkbox"/> more than 1 month |
| <input type="checkbox"/> 2-3 days | <input type="checkbox"/> more than 2 weeks | |

List any other health problems that your child has.

Dates	Problem	Health Care Provider
<hr/>		
<hr/>		
<hr/>		

List any mood or behavioral problems that your child has.

Dates	Problem	Health Care Provider
<hr/>		
<hr/>		

Do you have any current concerns regarding your child's mood or behavior? _____

List all family health problems including chronic pain, emotional and behavior problems and alcohol or substance abuse. Mark whether your child is aware of and/or has observed each condition.

Family member	Dates	Type of illness	Outcome	Child Aware/Observed
_____				<input type="checkbox"/> <input type="checkbox"/>
_____				<input type="checkbox"/> <input type="checkbox"/>
_____				<input type="checkbox"/> <input type="checkbox"/>
_____				<input type="checkbox"/> <input type="checkbox"/>

Are there any major life stresses in the family (such as divorce, separation, difficult financial burden, illness)? If yes, please list.

Were any major changes in your or your child's life happening when the pain started? Please explain.

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

If your child's pain were to be better managed, how would it change their life? _____

How would it change your life? _____

How would it change family relationships? _____

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

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



4800 Sand Point Way NE, PO Box 5371, M/S 9G-1
Seattle, WA 98105-0371
Phone 206-987-2704
Fax: 206-987-3935

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The Varni/Thompson Pediatric Pain Questionnaire: Form C (Child), unpublished manuscript.
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