Child and Adolescent Pain Questionnaire

Ages 8-18

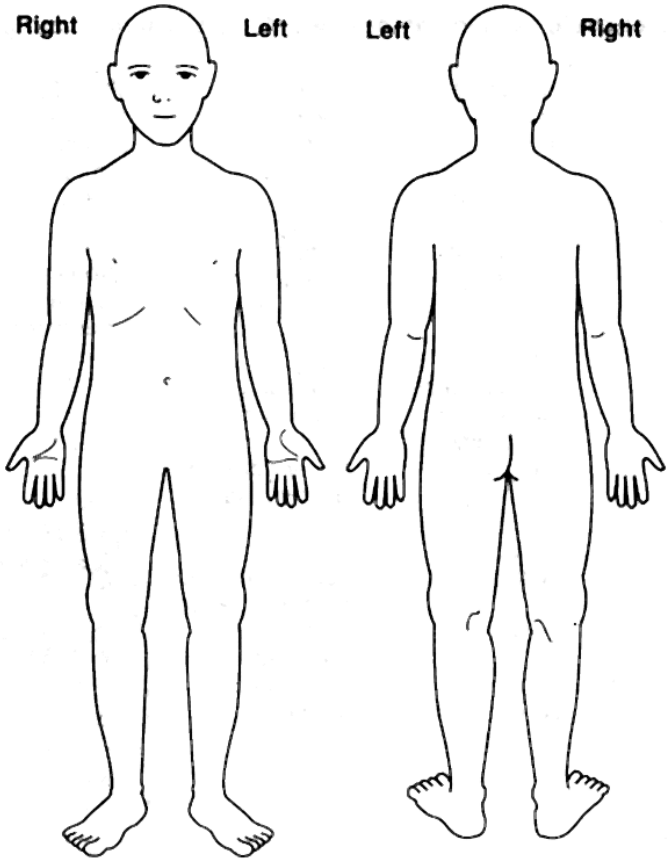
Your name: _____ Age: _____ Today's date: _____

About your pain

1. How long ago did your pain start?_____

2. What happened when your pain started? (for example, after an illness, injury) _____

_____



3. Mark with "X" to show where on your body you have had aches or pains.
4. Which part of your body do you have the **most** problems with aches or pains? _____

_____

5. How long do your aches or pains usually last? (Please circle)

Less than 1 hour A few hours Half of the day All day

6. Which statement best describes your pain? (tick one box only)
   - ❑ Always present (always the same intensity)
   - ❑ Always present (intensity varies)
   - ❑ Often present (pain free periods last less than 6 hours)
   - ❑ Occasionally present (pain occurs once to several times per day, lasting up to an hour)
   - ❑ Rarely present (pain occurs every few days or weeks)

7. How much do aches or pains limit or stop you from doing your usual activities? (Put an "X" anywhere on the line below)

Does not limit any activity _____ **Limits all activities**

8. Rate your pain (the most bothersome place on your body) by circling the one number that best describes the following:

a) How bothered and/or upset are you by your pain **right now?**	0 Not at all bothered	1	2	3	4	5	6	7	8	9	10 Very Bothered
b) Your **worst** pain in the last week?	0 No pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine
c) Your **least** pain in the last week?	0 No pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine
d) Your **usual** pain in the last week?	0 No pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine
e) How much pain do you have **right now?**	0 No pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine

Think about your activities over the **last 7 days**. Please rate how **difficult or bothersome** doing these activities was for you because of **pain**. If you don't participate in an activity, please mark "N/A".

		Not very difficult	A little difficult	Somewhat difficult	Very difficult	Extremely difficult	N/A
1.	Going to school	**0**	**1**	**2**	**3**	**4**	☐
2.	Gym	**0**	**1**	**2**	**3**	**4**	☐
3.	Reading	**0**	**1**	**2**	**3**	**4**	☐
4.	Schoolwork	**0**	**1**	**2**	**3**	**4**	☐
5.	Sports	**0**	**1**	**2**	**3**	**4**	☐
6.	Doing a hobby	**0**	**1**	**2**	**3**	**4**	☐

		Not very difficult	A little difficult	Somewhat difficult	Very difficult	Extremely difficult	N/A
7.	Playing with friends	0	1	2	3	4	☐
8.	Watching TV	0	1	2	3	4	☐
9.	Housework or chores	0	1	2	3	4	☐
10.	Working at a job	0	1	2	3	4	☐
11.	After school practices	0	1	2	3	4	☐
12.	Doing things with friends	0	1	2	3	4	☐
13.	Going to clubs/ church activities	0	1	2	3	4	☐
14.	Running	0	1	2	3	4	☐
15.	Walking up stairs	0	1	2	3	4	☐
16.	Eating regular meals	0	1	2	3	4	☐
17.	Riding in the school bus or car	0	1	2	3	4	☐
18.	Walking one or two blocks	0	1	2	3	4	☐
19.	Sleep	0	1	2	3	4	☐
20.	Riding a bike or scooter	0	1	2	3	4	☐
21.	Being up all day (without a nap or rest)	0	1	2	3	4	☐

About your mood

Below are some things that may happen to you when you have pain. Please check the box that best describes how much these things happen to you.

	Not at all	Mildly	Moderately	Severely	Extremely
1. When I have pain I worry all the time whether the pain will end	☐	☐	☐	☐	☐
2. When I have pain I feel I can't go on	☐	☐	☐	☐	☐
3. When I have pain it's terrible and I think it's never going to get better	☐	☐	☐	☐	☐
4. When I have pain it's awful and I feel it takes over me	☐	☐	☐	☐	☐
5. When I have pain I feel I can't stand it anymore	☐	☐	☐	☐	☐
6. When I have pain I'm afraid that the pain will get worse	☐	☐	☐	☐	☐
7. When I have pain I keep thinking of other painful events	☐	☐	☐	☐	☐
8. When I have pain I want the pain to go away	☐	☐	☐	☐	☐
9. When I have pain I can't keep it out of my mind	☐	☐	☐	☐	☐

	Not at all	Mildly	Moderately	Severely	Extremely
10.When I have pain I keep thinking about how much it hurts	☐	☐	☐	☐	☐
11.When I have pain I keep thinking about how much I want the pain to stop	☐	☐	☐	☐	☐
12.When I have pain there is nothing I can do to reduce the pain	☐	☐	☐	☐	☐
13.When I have pain I wonder whether something serious may happen	☐	☐	☐	☐	☐

Please respond to each question or statement by marking one box per row.

In the past 7 days...	Never 0	Almost Never 1	Sometimes 2	Often 3	Almost Always 4
1. I felt nervous.	☐	☐	☐	☐	☐
2. I felt scared.	☐	☐	☐	☐	☐
3. I felt worried.	☐	☐	☐	☐	☐
4. I felt like something awful might happen.	☐	☐	☐	☐	☐
5. I thought about scary things.	☐	☐	☐	☐	☐
6. I was afraid that I would make mistakes.	☐	☐	☐	☐	☐
7. I worried about what could happen to me.	☐	☐	☐	☐	☐
8. I worried when I went to bed at night.	☐	☐	☐	☐	☐

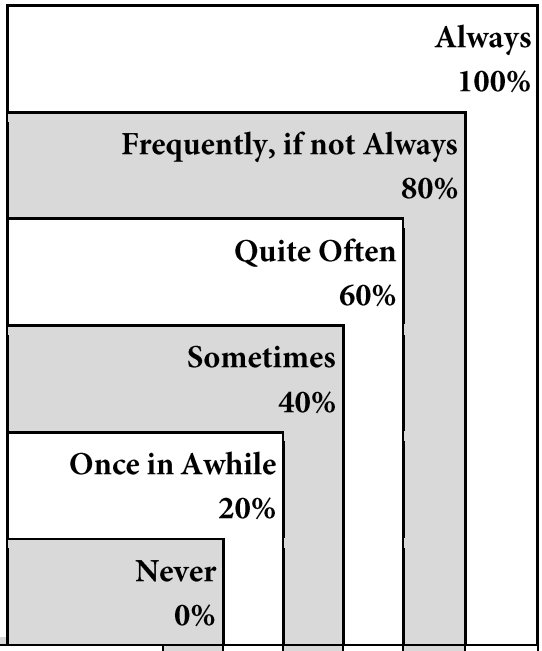
Please respond to each question or statement by marking one box per row.

In the past 7 days...	Never 0	Almost Never 1	Sometimes 2	Often 3	Almost Always 4
1. I could not stop feeling sad.	☐	☐	☐	☐	☐
2. I felt alone.	☐	☐	☐	☐	☐
3. I felt everything in my life went wrong.	☐	☐	☐	☐	☐
4. I felt like I couldn't do anything right.	☐	☐	☐	☐	☐
5. I felt lonely.	☐	☐	☐	☐	☐
6. I felt sad.	☐	☐	☐	☐	☐
7. I felt unhappy.	☐	☐	☐	☐	☐
8. I thought that my life was bad.	☐	☐	☐	☐	☐

About your sleep

Using the choices below, circle **how often** the following things have happened **during the past month.**

Never – has not happened
Once in Awhile – happened 20% of the time
Sometimes – happened 40% of the time
Quite Often – happened 60% of the time
Frequently, if not always – happened 80% of the time
Always – happened 100% of the time



1.	When its time to go to bed, I want to stay up and do other things (for example: watch TV, play video games, or talk on the phone).	N	O	S	Q	F	A
2.	In general, I am ready for bed at bedtime.	N	O	S	Q	F	A
3.	In general, I try to "put off" or delay going to bed.	N	O	S	Q	F	A
4.	When it's time to go to sleep (lights-out), I have trouble settling down.	N	O	S	Q	F	A
5.	In general, I need help getting to sleep (for example: I need to listen to music, watch TV, take medication, or have someone else in the bed with me).	N	O	S	Q	F	A
6.	After waking up in the night, I have trouble going back to sleep.	N	O	S	Q	F	A
7.	After waking up in the night, I have trouble getting comfortable.	N	O	S	Q	F	A
8.	After waking up in the night, I need help to go back to sleep (for example: I need to watch TV, read, or sleep with another person).	N	O	S	Q	F	A
9.	In the morning, I wake up and feel ready to get up for the day.	N	O	S	Q	F	A
10.	In the morning, I wake up feeling rested and alert.	N	O	S	Q	F	A

1. What is your usual bedtime on school days: _____ a.m./p.m.
2. What is your usual bedtime when you do not have school: _____ a.m./p.m.
3. What time of day do you usually wake up on school days: _____ a.m./p.m.
4. What time of day do you usually wake when you do not have school: _____ a.m./p.m.
5. How many naps do you take per week? _____ naps
6. Write the number of minutes a nap usually lasts: _____ minutes

About school

1. How much has pain interfered with your school attendance?

0	1	2	3	4	5	6	7	8	9	10
Did not interfere at all										Interfered extremely

2. How much has pain interfered with your performance (e.g., grades) at school?

0	1	2	3	4	5	6	7	8	9	10
Did not interfere at all										Interfered extremely

Tell us more about your pain

1. If your pain were to be better managed, how would your life be different? _____

_____

2. What do you think is causing your pain? _____

_____

3. What else would you like us to know about your pain? _____

_____

4. What is your goal for coming to Pain Clinic? _____

_____

To Learn More

Pain Medicine Clinic, 206-987-1520
Option 1: Appointment Scheduling
Option 2: Procedure Scheduling
Option 4: Pain Clinic Nurse

Please return this completed form by fax, email, or mail before your visit

- Fax: 206-985-3384
- Email: PainForm@seattlechildrens.org

Mail: (call 206-987-1520, option 1 to request a stamped envelope)

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