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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Age</th>
<th>Gender</th>
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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.”
When did your child's present pain problem begin? Explain the symptoms and exact locations of pain.

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

My child’s pain:  □ is always there  □ comes and goes  □ is always there but sometimes gets worse

My child’s pain is:  □ staying the same  □ getting worse  □ getting better

Mark the words below that best describe your child’s pain, or the way your child feels when hurt or in pain.

□ cutting  □ pounding  □ tingling  □ tiring  □ deep
□ squeezing  □ throbhing  □ 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 think your child is having at the present time 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 think your child has on an average each day by placing a mark somewhere on the line.

Not hurting  No discomfort  No pain

Hurting a whole lot  Very uncomfortable  Severe pain

Rate how severe the worst pain your child 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 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.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>How often</th>
<th>How Effective</th>
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</table>

0 = not effective
10 = very effective
List any other medications you have tried in the past for your child’s pain.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>How often</th>
<th>How Effective</th>
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List any other medications your child is currently taking.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>How often</th>
<th>Reason</th>
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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.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoying the family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Eating/appetite</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Sleeping</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Seeing friends</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Watching T.V.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Schoolwork</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Attending school</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Favorite activities</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Other activities</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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Comments? ________________________________
During the past three months of the school year, how often did your child’s pain keep them from going to school?

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

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?

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

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?

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

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?

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

List any other health problems that your child has.

<table>
<thead>
<tr>
<th>Dates</th>
<th>Problem</th>
<th>Health Care Provider</th>
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List any mood or behavioral problems that your child has.

<table>
<thead>
<tr>
<th>Dates</th>
<th>Problem</th>
<th>Health Care Provider</th>
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Do you have any current concerns regarding your child’s mood or behavior? 
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___________________________________________________________________________________

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.

<table>
<thead>
<tr>
<th>Family member</th>
<th>Dates</th>
<th>Type of illness</th>
<th>Outcome</th>
<th>Child Aware/Observed</th>
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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?
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
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