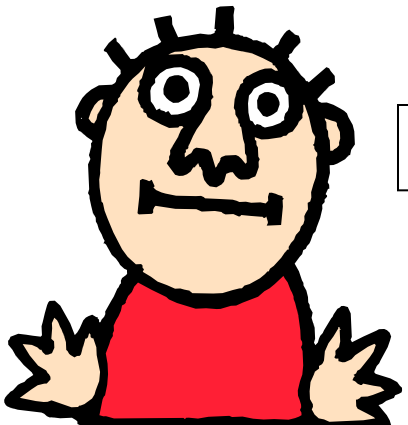
# The Barolat Institute
# Pain Evaluation Questionnaire

Thank you for filling out this questionnaire.

This information will be invaluable in helping us understand your problem.

Please be as thorough as possible in answering all the appropriate questions.



PLEASE HELP US HELP YOU !!!!!

# The Barolat Institute
# Pain Evaluation Questionnaire

Name _____ Date_____

Please score your pain for the various body parts listed below (score all body parts)

*Circle the appropriate responses*

## Average Pain

| | Pain Level | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Face** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Head** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Neck** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Shoulder Blade** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Shoulder** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Chest** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Back Thoracic** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Back Lumbar** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Abdomen** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Private Parts** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Arm(s)** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Leg(s)** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Other** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

## Worst Pain

| | Pain Level | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Face** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Head** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Neck** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Shoulder Blade** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Shoulder** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Chest** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Back Thoracic** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Back Lumbar** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Abdomen** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Private Parts** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Arm(s)** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Leg(s)** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Other** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

# The Barolat Institute
# Pain Evaluation Questionnaire

Name _____

***The Questions In This Section Pertain To Your WORST Pain And/Or The Pain You Are Trying To Address In This Consultation***
***(if you have a second worst pain area fill the next page as well)***

What body part are you addressing in this section?

a. Head
b. Face
c. Neck
d. Upper back (at shoulder blades level)
e. Midback (above beltline)
f. Low back (below beltline)
g. Shoulder(s)
h. Chest
i. Abdomen
j. Flank
k. Private parts
l. Arm(s)
m. Leg(s)
n. Other _____

Describe your pain ( select up to 3 choices and circle the order of importance )

1 2 3 Sharp
1 2 3 Dull
1 2 3 Aching
1 2 3 Stabbing
1 2 3 Shooting
1 2 3 Burning
1 2 3 Tearing
1 2 3 Lightening bolt

How frequent is your pain?

a. Constant
b. Not constant: every day frequently
c. Not constant: every day infrequently
d. Not constant: not every day

How long have you had the pain?

a. Less than a month
b. 1-6 months
c. 6-12 months
d. More than one year

Do you have any of the following in the pain area?

a. Swelling
b. Change in color
c. Change in temperature
d. Pain/discomfort even to light touch
e. Air blowing causes pain/discomfort
f. The water in the shower causes pain/discomfort
g. Sheets in bed bother me

How bad is the pain? (at its worst)

a. Excruciating
b. Severe
c. Moderate
d. Mild

How bad is the pain? (at its least)

a. Excruciating
b. Severe
c. Moderate
d. Mild

How is your pain at night?

a. No pain
b. Much less than during the day
c. Less than during the day
d. Just as bad as during the day

Does your pain wake you up at night?

a. Never
b. Seldom
c. Often
d. Always

Are you numb in the area of worst pain?

a. Yes constantly
b. Yes at times
c. No

# The Barolat Institute
# Pain Evaluation Questionnaire

Name _____

***The Questions In This Section Pertain To Your SECOND WORST Pain (If you have one)***

What body part are you addressing in this section?

a. Head
b. Face
c. Neck
d. Upper back (at shoulder blades level)
e. Midback (above beltline)
f. Low back (below beltline)
g. Shoulder(s)
h. Chest
i. Abdomen
j. Flank
k. Private parts
l. Arm(s)
m. Leg(s)
n. Other _____

Describe your pain ( select up to 3 choices and circle the order of importance )

1 2 3 Sharp
1 2 3 Dull
1 2 3 Aching
1 2 3 Stabbing
1 2 3 Shooting
1 2 3 Burning
1 2 3 Tearing
1 2 3 Lightening bolt

How frequent is your pain?

a. Constant
b. Not constant: every day frequently
c. Not constant: every day infrequently
d. Not constant: not every day

How long have you had the pain?

a. Less than a month
b. 1-6 months
c. 6-12 months
d. More than one year

Do you have any of the following in the pain area?

a. Swelling
b. Change in color
c. Change in temperature
d. Pain/discomfort even to light touch
e. Air blowing causes pain/discomfort
f. The water in the shower causes pain/discomfort
g. Sheets in bed bother me

How bad is the pain? (at its worst)

a. Excruciating
b. Severe
c. Moderate
d. Mild

_____

How bad is the pain? (at its least)

a. Excruciating
b. Severe
c. Moderate
d. Mild

How is your pain at night?

a. No pain
b. Much less than during the day
c. Less than during the day
d. Just as bad as during the day

Does your pain wake you up at night?

a. Never
b. Seldom
c. Often
d. Always

Are you numb in the area of worst pain?

a. Yes constantly
b. Yes at times
c. No

Name _____

***If your worst pain (or the pain we are trying to address) is in your LEG(S)*** → ***Fill This Section***

Where is your leg pain?

a. Only one leg
b. Both legs to the same degree
c. Both legs; One leg is much worse than the other
d. Both legs; One leg is slightly worse than the other

What effects does activity have on your leg pain?

a. No effect on the pain
b. Minimal effect on the pain
c. Makes the pain definitely worse

Where is the distribution of your your worst leg pain?

a. The whole leg
b. Parts of the leg, in a narrow strip distribution
c. Parts of the leg, in widespread areas
d. Parts of the leg, in a small area

In what parts of your leg is the worst pain ? (circle as many as you wish)

a. Front of thigh b. Back of thigh c. Knee d. Between knee and foot e . Ankle f. Foot

Does your leg swell even when you lie flat?

a. Yes b. No

Does your leg(s) ever give out on you?

a. Yes b. No

Do you have problems voiding ?

a. Yes b. No

How long have you had problems voiding ?

a. Less than 6 months b. More than 6 months

***If your worst pain (or the pain we are trying to address) is in your ARM(S)*** → ***Fill This Section***

What effects does activity have on your arm pain?

a. No effect on the pain
b. Minimal effect on the pain
c. Makes the pain definitely worse

If you use the arm extensively, how long does it take for the pain to come on?

a. Immediately
b. After a few minutes
c. After a few hours
d. The next day

When you stop using the arm, how long will the pain last?

a. Minutes
b. Hours
c. Days

Do you have increased pain when you keep the arm elevated at or above the head level? a. Yes b. No

Does your arm fatigue and hurt more with repetitive activity (such as writing)? a. Yes b. No

Do you have pain in the upper chest area? a. Yes b. No

Where is your arm pain?

a. Only one arm
b. Both arms to the same degree
c. Both arms. One arm is much worse than the other
d. Both arms. One arm is slightly worse than the other

Where is your worst arm pain? (select as many choices as you want)

a. Above the elbow
b. Between the elbow and the wrist
c. Wrist
d. Hand

Where is the distribution of your worst arm pain?

a. The whole arm
b. Parts of the arm, in a narrow strip distribution
c. Parts of the arm , in widespread areas
d. Parts of the arm, in a small area

## If your main problem is HEADACHES/PAIN IN THE FACE
*Fill This Section*

Where is your worst pain?
(Circle no more than 3 choices)

a. Neck
b. Back of the head
c. Front of the head
d. Forehead
e. Jaw
f. Cheekbone
g. Ear
h. Mouth

Where is the distribution of your pain?
a. Only on one side b. Both sides c. In the center

How large is the area of your worst pain?

a. A quarter
b. A fist
c. Two fists
d. Larger than two fists

## If your main problem is pain in OTHER PARTS OF THE BODY (including NECK and BACK)
*Fill This Section*

Where is your worst pain? (Circle no more than 3 choices)

a. Neck
b. Upper back (at shoulder blades level)
c. Midback (above beltline)
d. Low back (below beltline)
e. Shoulder(s)
f. Chest
g. Abdomen
h. Flank
i. Private parts

Where is the distribution of your pain?
a. Only on one side b. Both sides c. In the center

How large is the area of your worst pain?

a. A quarter
b. A fist
c. Two fists
d. Larger than two fists

## For patients who have had previous surgery related to the existing problem (except spine surgery)

*Fill This Section*

How many surgeries have you had? (Count only the ones meant to address your current pain problem)
a. 1 b. 2 c. More than 2

Did any of the surgeries help you with your current pain for more than 6 months?
a. Yes b. Maybe c. No

Was your pain permanently worse after one of the surgeries?
a. Yes b. No c. Hard to tell

## For patients who have had previous SPINE surgery related to the existing problem

*Fill This Section*

How many surgeries have you had? (Count only the ones meant to address your current pain problem) a. 1 b. 2 c. More than 2

Did any of the surgeries help you with your current arm / leg pain for more than 6 months?
a. Yes b. Maybe c. No d. N/A

Did any of the surgeries help you with your current neck/back pain for more than 6 months?
a. Yes b. Maybe c. No d. N/A

Was your arm / leg/neck / back pain permanently worse after one of the surgeries?
a. Yes b. No c. Hard to tell

# The Barolat Institute
## Pain Evaluation Questionnaire: Functional Assessment

Name_____

**What impact does the pain have on your life?**

Minimal Moderate Major

| | |
|---|---|
| **What was your activity level prior to the onset of the pain problem?**<br>☐ Sedentary<br>☐ Moderately active<br>☐ Very active | **What is your activity level now?**<br>☐ Sedentary<br>☐ Moderately active<br>☐ Very active |
| **Were you actively involved with sports prior to the pain problem?**<br>☐ Yes, Very Much<br>☐ Yes, Moderately<br>☐ Yes, Minimally<br>☐ No | **Are you involved with sports now?**<br>☐ Yes, Very Much<br>☐ Yes, Moderately<br>☐ Yes, Minimally<br>☐ No |
| **How do you spend most of your day?**<br>☐ At home in bed<br>☐ At home on the couch<br>☐ At home actively performing chores<br>☐ I go out a few hours and then at home<br>☐ I am out at least 8 hours per day | |
| **What hobbies did you have prior to the pain problem?** | **What hobbies do you have now?** |
| **Work prior to pain problem**<br>☐ Full time<br>☐ Part time<br>☐ Unemployed<br>☐ Student<br>☐ Disability<br>☐ Other | **Work now**<br>☐ Full time<br>☐ Part time<br>☐ Unemployed<br>☐ Student<br>☐ Disability<br>☐ Other |
| **What are the activities that you would like to perform if the treatment is successful in reducing your pain? (Pick 3 and be realistic)**<br>☐_____<br>☐_____<br>☐_____ | |