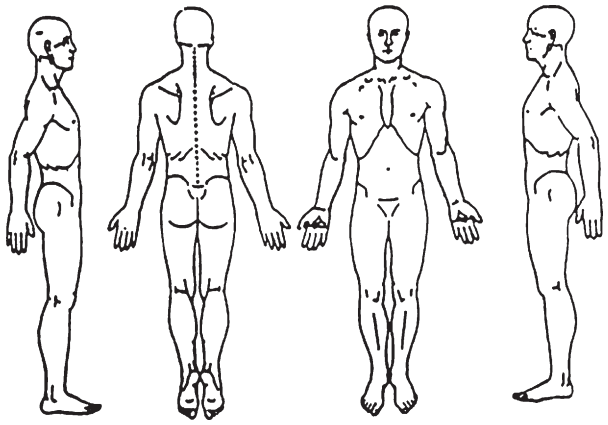
SWEDISH
Extraordinary care. Extraordinary caring.℠

SWEDISH PAIN SERVICES:
Follow-up Questionnaire

Name _____ Date of Birth _____ Today's Date _____

Please indicate where your present pain is:



What number best describes your pain ***on average in the last week***:

No pain — Pain as bad as you can imagine

0	1	2	3	4	5	6	7	8	9	10

What number best describes how, ***during the last week***, pain has interfered with your:

	No interference 0	1	2	3	4	5	6	7	8	9	Complete interference 10
Enjoyment of life											
General Activity											

Please list the important activity you chose at the last visit that is currently difficult for you to perform:

_____

_____

How would you rate the difficulty you have performing this activity ***over past week***?

No difficulty — Extreme difficulty

0	1	2	3	4	5	6	7	8	9	10

In the past month, how many days have you had where you felt you needed to take more pain medication than your doctor is currently prescribing? ☐ None ☐ 1 – 2 ☐ 3 – 4 ☐ 5 or more

Fatigue/tiredness	**None**	**Mild**	**Severe**	**Very Severe**
How would you rate your fatigue ***on average***?				

Please answer every section, and *mark in each section the one box that applies to you.* We realize you may consider that two of the statements in any one section relate to you, but *please mark the box that most clearly describes your problem.*

Section 1- Pain intensity:

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2 - Personal care (washing, dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself, and I am slow and careful.
- ☐ I need some help but I manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed. I wash with difficulty and stay in bed.

Section 3 - Lifting:

- ☐ I can lift heavy weights without causing extra pain I
- ☐ can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned (eg. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Walking:

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can walk using a stick or crutches.
- ☐ I am in bed most of the time

Section 5 - Sitting:

- ☐ I can sit in any chair for as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 - Standing:

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 - Sleeping:

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of my pain I have less than 6 hours sleep.
- ☐ Because of my pain I have less than 4 hours sleep.
- ☐ Because of my pain I have less than 2 hours sleep..
- ☐ Pain prevents me from sleeping at all.

Section 8 - Sex life (if applicable):

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevent any sex life at all

Section 9- Social life:

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal, but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, eg, sport
- ☐ Pain has restricted my social life, and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 10 - Travelling:

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere, but it gives me extra pain.
- ☐ Pain is bad, but I manage journeys over two hours.
- ☐ Pain restricts me to journeys of less than one hour.
- ☐ Pain restricts me to necessary journeys under 30 minutes
- ☐ Pain prevents traveling except to receive treatment.

Depression and anxiety

In the past 2 weeks...

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious on edge	❑	❑	❑	❑
Not being able to control or stop worrying	❑	❑	❑	❑
Worrying too much about different things	❑	❑	❑	❑
Trouble relaxing	❑	❑	❑	❑
Being so restless that it's hard to sit still	❑	❑	❑	❑
Becoming easily annoyed or irritable	❑	❑	❑	❑
Feeling afraid as if something awful might happen	❑	❑	❑	❑

	Not at all	Several days	Over half the days	Nearly every day
Little interest or no pleasure in doing things	❑	❑	❑	❑
Feeling down, depressed, or hopeless	❑	❑	❑	❑
Trouble falling or staying asleep, or sleeping too much	❑	❑	❑	❑
Feeling tired or having little energy	❑	❑	❑	❑
Poor appetite or overeating	❑	❑	❑	❑
Feeling bad about yourself – or that you are a failure or you have let yourself or family down	❑	❑	❑	❑
Trouble concentrating on things, such as the newspaper or watching television	❑	❑	❑	❑
Moving or speaking so slowly that other people have noticed. Or the opposite – being so fidgety or restless that you have been moving around more than usual	❑	❑	❑	❑
Thoughts that you would be better off dead or hurting yourself	❑	❑	❑	❑

	Very poor	**Poor**	**Fair**	**Good**	**Very Good**
My sleep quality was					

Sleep Disturbance in the past seven days

In the past 7 days	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
My sleep was refreshing					
I had a problem with my sleep					
I had difficulty falling asleep					
My sleep was restless					
I tried hard to get to sleep					
I worried about not being able to sleep					
I was satisfied with my sleep					

Have you developed any new allergies recently? ..... ☐ Yes ☐ No

What ***pain*** medications are you taking eg Percocet, oxycodone, hydrocodone, gabapentin?

Name of drug	Strength	Number per day

Have you had any changes to your medications since last seen? ..... Yes ☐ No ☐

Do you need any refills of your medications today? ..... Yes ☐ No ☐

Are you getting side effects from your medications you would like to discuss?
For example: constipation, dry mouth, drowsiness, dizziness, nausea?..... Yes ☐ No ☐

Have you had any serious illness, hospitalization or surgery since last visit? ..... Yes ☐ No ☐

If yes what was the event?

_____

Please list any concerns, in order of importance, which you would like to discuss today:

_____

_____

_____

_____

_____

Did you achieve any of the goals you set for yourself at the last visit?

☐ Did not try ☐ Almost achieved ☐ Achieved ☐ Achieved and more