Dorset Pain Management Service
Personal Information Form

Dorset HealthCare University NHS Foundation Trust

Before completing this form please watch our video to make sure that the service is right for you. Please go to our website at www.dorsetpain.org.uk

1. Personal Information

Date _____/_____/_____ **NHS No.** _____

Full Name _____

Home Telephone _____ Sex: Female ☐ Male ☐

Mobile _____ Date of Birth: _____/_____/_____ (DD / MM / YEAR)

Are we able to leave a message on your phone? Yes ☐ No ☐

Email address _____

Are you happy for us to email you? Yes ☐ No ☐

Please indicate your current marital status:

Single ☐ **Married** ☐ **Co-habiting** ☐ **Civil Partnership** ☐ **Divorced/Separated** ☐ **Widowed** ☐

Please describe your current family set-up (*include the names, ages and relationship of family members and significant relationships)*:

Do you drive or do you have ready access to transport?

2. Occupational Experiences

2.1 Please indicate which of the following options best describes your current status:

Employed full-time (30 hours or more per week)	☐	Homemaker	☐
Employed part-time	☐	Carer	☐
Self employed	☐	Voluntary work	☐
Unemployed	☐	Retired	☐
Full time student	☐	Other (please state)	☐

2.2 If you are employed, please provide details of current occupation:

2.3 If you are not currently employed, please provide details/date of the last post you have held. When did you stop working and what were the reasons for doing so?

2.4 Are you currently receiving benefits? YES / NO

If yes, please provide details:

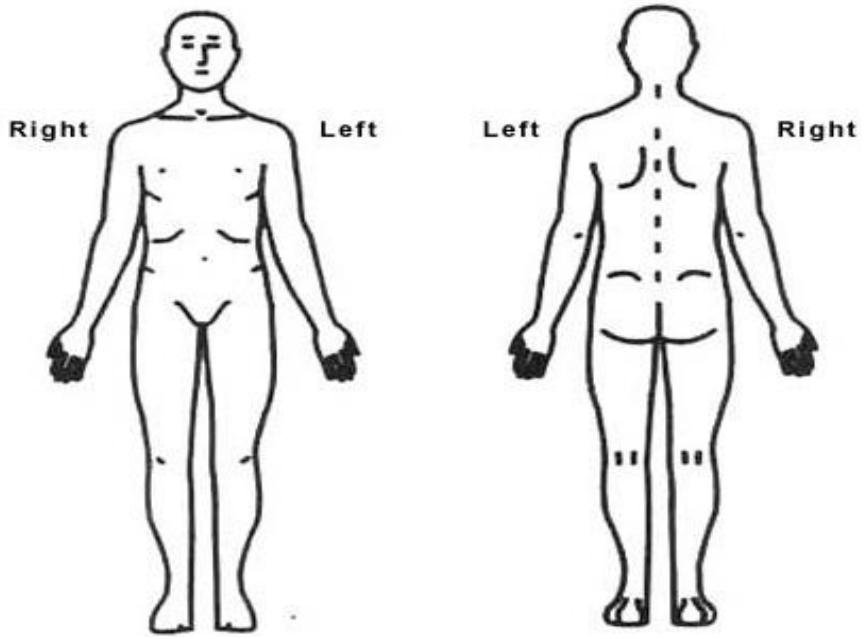
2.5 If you are you currently employed, is your employer supportive of your needs? Are there any stressors at work which contribute to your pain? *Please explain*

3. About Your Pain

3.1 What do you think is the cause of your pain?

3.2 How long have you been in discomfort? Was there a gradual or sudden onset? *(If different parts of your body are affected, please tell us about them separately.)*

3.3 On the diagram, shade in the areas that are affected. Put an X on the area that is most affected.



3.4 Please rate your pain by circling the <u>one</u> number that best describes your pain at its <u>worst</u> in the <u>last week</u>:

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain

3.5 Please rate your pain by circling the <u>one</u> number that best describes your pain at its <u>least</u> in the <u>last week</u>:

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain

3.6 Please rate your pain by circling the <u>one</u> number that best describes your pain on the <u>average</u>:

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain

3.7 Please rate your pain by circling the <u>one</u> number that best describes how much pain you have <u>right now</u>:

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain

3.8 What kinds of things make your pain better (e.g. heat, medicine, rest)?

3.9 What kinds of things make your pain worse (e.g. walking, standing, lifting)?

A. LEARN MORE ABOUT YOUR PAIN	B. BUILD A HEALTHY LIFESTYLE	C. DO WHAT MATTERS TO YOU	D. ENHANCE EMOTIONAL WELL-BEING
1. Understand the pain system ☐	1. Understand your body ☐	1. Find creative ways of fulfilling your valued goals ☐	1. Explore how persistent pain can make you think and feel ☐
2. Dispel myths or misunderstandings about chronic pain, the mind and the body ☐	2. Increase confidence in movement ☐	2. Balance your activities and pace yourself ☐	2. Tackle stress, anxiety and low mood ☐
3. Understand the usefulness of appropriate medication ☐	3. Develop strength and fitness through movement and exercise ☐	3. Manage daily household tasks and responsibilities ☐	3. Come to terms with past experiences, trauma and losses ☐
4. Understand the pros and cons of medical interventions ☐	4. Improve balance and co-ordination ☐	4. Signpost to financial advice and guidance ☐	4. Improve communication… learn to say 'NO' when needed ☐
5. Come to terms with having persistent pain ☐	5. Learn about how to improve your sleep ☐	5. Build back your leisure and social activities ☐	5. Acknowledge your strengths and achievements ☐
	6. Manage flare-ups effectively ☐	6. Enhance wellbeing through employment, volunteering and learning ☐	6. Take back control of your life ☐
	7. Practice relaxation, meditation and/or mindfulness ☐	7. Build your support team ☐	

4.1 Our **4 PILLARS MODEL** of pain management includes a variety of skills people find helpful to learn while dealing with their condition. While you may gain many skills to help you manage more effectively, it is really important that we help you gain the skills which you feel are most important to you. ***Please read the list carefully and choose the top 5 skills you would like to work on to manage your situation better. You may choose more than one skill from each Pillar, but we would like you just to choose 5 overall.***

Number them in order of priority in the boxes provided next to each item

4.2 Managing your condition is like any other skill: it takes time to learn and practice. How much time are you willing and able to devote to practicing the management strategies you've selected overleaf?

Minutes per day: 1-30 □ 30-60 □ 60-120 □

4.3 In order to derive maximum benefit, using new strategies requires your active participation and daily practice. Could you briefly mention anything in your life at the moment which may interfere with your ability to work on new strategies?

4.4 Persistent pain is extremely challenging to live with: what inner strength and resources have you developed to deal with the experience of living with it which will help you learn more about managing this condition?

5. Treatments

5.1 Current PAIN Medication (please list all the medicines, creams, patches or herbal remedies, prescribed or bought over-the-counter).

Medication/form	Dose (strength)	Frequency/time/ include whether taken every day	Duration	Comments (e.g. side effects)	Effective (out of 10)

Please continue on a separate sheet if necessary

5.2 PAIN medication tried but no longer taking (please list all the medicines, creams, patches or herbal remedies, prescribed or bought over the counter).

Medication/form	Dose (strength)	Frequency/ include whether taken every day	Duration and date when stopped	Comments (e.g. side effects). Effectiveness (out of 10)

Please continue on a separate sheet if necessary

5.3 Medications not prescribed by my doctor that I take for pain are:

5.4 Allergies / adverse reactions

5.5 Other interventions:

	Not Helpful					Very Helpful
Physiotherapy	0	1	2	3	4	5
Exercise / leisure centre	0	1	2	3	4	5
Healthy Back Programme	0	1	2	3	4	5
Expert Patient Programme	0	1	2	3	4	5
IAPT / Talking Therapies	0	1	2	3	4	5
TENS	0	1	2	3	4	5
Acupuncture	0	1	2	3	4	5
DOTS / OMS	0	1	2	3	4	5
Injection Therapy	0	1	2	3	4	5
Substance Misuse Referral	0	1	2	3	4	5
Private Interventions	0	1	2	3	4	5
Other	0	1	2	3	4	5
Please list:						

5.6 Are you involved with any other health, social or talking services e.g. CMHT, Steps 2 Wellbeing etc.?

6. Thoughts and Feelings

Everyone experiences painful situations at some point in their lives. We are interested in the types of thoughts and feeling that you have when these moments occur. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

When I'm in pain …..

0 – not at all **1** – to a slight degree **2** – to a moderate degree **3** – to a great degree **4** – all the time

1		I worry all the time about whether the pain will end
2		I feel I can't go on
3		It's terrible and I think it's never going to get any better
4		It's awful and I feel that it overwhelms me
5		I feel I can't stand it anymore
6		I become afraid that the pain will get worse
7		I keep thinking of other painful events
8		I anxiously want the pain to go away
9		I can't seem to keep it out of my mind
10		I keep thinking about how much it hurts
11		I keep thinking about how badly I want the pain to stop
12		There's nothing I can do to reduce the intensity of the pain
13		I wonder whether something serious may happen

Official use only

7. Living with pain

Which of the following apply to you?

Do you suffer from a burning sensation (e.g., stinging nettles) in the marked areas?
Never ☐ Hardly noticed ☐ Slightly ☐ Moderately ☐ Strongly ☐ Very strongly ☐

Do you have a tingling or prickling sensation in the area of your pain (like crawling ants or electrical tingling)?
Never ☐ Hardly noticed ☐ Slightly ☐ Moderately ☐ Strongly ☐ Very strongly ☐

Is light touching (e.g., clothing, a blanket) in this area painful?
Never ☐ Hardly noticed ☐ Slightly ☐ Moderately ☐ Strongly ☐ Very strongly ☐

Do you have sudden pain attacks in the area of your pain, like electric shocks?
Never ☐ Hardly noticed ☐ Slightly ☐ Moderately ☐ Strongly ☐ Very strongly ☐

Is cold or heat (e.g., bath water) in this area occasionally painful?
Never ☐ Hardly noticed ☐ Slightly ☐ Moderately ☐ Strongly ☐ Very strongly ☐

Do you suffer from a sensation of numbness in the areas that you marked?
Never ☐ Hardly noticed ☐ Slightly ☐ Moderately ☐ Strongly ☐ Very strongly ☐

Does slight pressure in this area, e.g., with a finger, trigger pain?
Never ☐ Hardly noticed ☐ Slightly ☐ Moderately ☐ Strongly ☐ Very strongly ☐

The information you share with us will be held confidentially within the Dorset Community Pain Service in line with Dorset HealthCare University NHS Foundation Trust clinical and information governance policies.

Please return your **completed** form to:

Your GP Practice so they can complete the referral

If you have any difficulty in filling this form, please call us on 01305 213040
or email us on dhc.dorset.cps@nhs.net