### Personal Details:

- **Name:**

- **Contact Details:**

### Spinal Cord Injury (SCI) Details:

<table>
<thead>
<tr>
<th>Level of SCI:</th>
<th>Date of SCI:</th>
<th>Type of SCI:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete</td>
<td>12/31/2023</td>
<td>□ Complete</td>
</tr>
<tr>
<td>Incomplete</td>
<td></td>
<td>□ Incomplete</td>
</tr>
</tbody>
</table>

- **AIS # (if known):**
  - □ A
  - □ B
  - □ C
  - □ D

  NB: If AIS unknown leave this column blank.

(\# American Spinal Cord Injury Association Impairment Scale AIS describes the sensory & motor level of SCI according to the International Standards for the Neurological Classification of Spinal Cord Injury)

### Health Screening Questions:

In the table below tick all that apply to your current pain problem:

- □ This is a new pain (pain in a new location or pain that has new characteristics)
- □ This is a significant flare up (or worsening) of an existing pain
- □ There has been a recent change in my level of sensation
- □ There has been a recent decrease in my muscle strength or function
- □ I have had a fever and / or chills
- □ I have noticed nausea, a lack of appetite and/or weight loss
- □ This pain causes me to have symptoms of Autonomic Dysreflexia
- □ I have noticed a recent change in my bladder function
  - (may include symptoms of bladder infection, bladder leakage, difficulty emptying)
- □ I have noticed a recent change in my bowel function
  - (may include constipation, bowel accidents, abdominal pain, bloating, rectal bleeding)
- □ I have a current area of skin breakdown
- □ I have had a recent fall or trauma
- □ There has been an increase in my muscle spasms

Discuss ticked items with your Doctor or Health Professional as soon as possible

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**NSW Lifetime Care & Support Authority**

**THE SPINAL CORD INJURY
PAIN QUESTIONNAIRE**

1. Have you had any pain during the last 7 days including today? *
   - Yes
   - No

2. In general, how much has pain interfered with your day-to-day activities in the last week? *
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   *(where 0 = no interference and 10 = extreme interference)*

3. In general, how much has pain interfered with your overall mood in the last week? *
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   *(where 0 = no interference and 10 = extreme interference)*

4. In general, how much has pain interfered with your ability to get a good night’s sleep? *
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   *(where 0 = no interference and 10 = extreme interference)*

5. How many different pain problems do you have? *
   - 1
   - 2
   - 3
   - 4
   - ≥ 5

6. Average pain intensity in the past week? 
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   *(where 0 = no pain and 10 = pain as bad as you can imagine)*

For your worst pain, provide the following details:

6. Where is the pain located? 

7. Is the pain above or below your level of SCI? **
   - Above
   - Below

8. Is the pain in a region of reduced sensation? **
   - Yes
   - No

9. When did the pain start? (Date of onset*)
   - ____/____/_____

10. Was there an event that triggered the pain?
    - Yes
    - No
    Details: __________________________

11. What words best describe your pain? **
    *(tick all that apply)*
    - Aching
    - Burning
    - Dull
    - Icy cold
    - Cramping
    - Electric Shocks
    - Tender
    - Pins & Needles
    - Squeezing
    - Tingling
    - Sharp
    - Other: ___________

12. How does pain change over the course of the day?

** Questions to help identify SCI Pain Type - International Spinal Cord Injury Pain Classification (Bryce et al 2012)
13. What makes the pain feel worse? **

- Personal care
- Mobility - transfers
- Mobility – wheelchair
- Mobility – walking
- Exercise/recreation/ sport
- Spasm
- Other: __________

14. What makes the pain feel better? **

- Rest
- Position/posture change
- Activity Pacing
- Other: __________

15. What medications do you use for pain?

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Helpful?</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

16. Are you using or receiving any treatments for your pain problem?   Y   N

17. Treatment Details:


If you have more than one pain problem, please download the additional pages of the questionnaire and repeat these questions for your 2nd and 3rd worst pain.
**THE SPINAL CORD INJURY PAIN QUESTIONNAIRE**

For your second worst pain, provide the following details:

<table>
<thead>
<tr>
<th>Question</th>
<th>Details 1</th>
<th>Details 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where is the pain located?</td>
<td>__________</td>
<td></td>
</tr>
<tr>
<td>Is the pain above or below your level of SCI? **</td>
<td>□ Above</td>
<td>□ Below</td>
</tr>
<tr>
<td>Is the pain in a region of reduced sensation? **</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>When did the pain start? (Date of onset*)</td>
<td><em><strong><strong>/</strong></strong></em>/_______</td>
<td></td>
</tr>
<tr>
<td>Was there an event that triggered the pain?</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Details:</td>
<td>__________</td>
<td></td>
</tr>
<tr>
<td>What words best describe your pain? ** (tick all that apply)</td>
<td>□ Aching</td>
<td>□ Burning</td>
</tr>
<tr>
<td></td>
<td>□ Dull</td>
<td>□ Icy cold</td>
</tr>
<tr>
<td></td>
<td>□ Cramping</td>
<td>□ Electric Shocks</td>
</tr>
<tr>
<td></td>
<td>□ Tender</td>
<td>□ Pins &amp; Needles</td>
</tr>
<tr>
<td></td>
<td>□ Squeezing</td>
<td>□ Tingling</td>
</tr>
<tr>
<td></td>
<td>□ Sharp</td>
<td>□ Other: ________</td>
</tr>
<tr>
<td>How does pain change over the course of the day?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What makes the pain feel worse? **</td>
<td>□ Personal care</td>
<td>□ Fatigue</td>
</tr>
<tr>
<td></td>
<td>□ Mobility - transfers</td>
<td>□ Stress</td>
</tr>
<tr>
<td></td>
<td>□ Mobility – wheelchair</td>
<td>□ Anxiety</td>
</tr>
<tr>
<td></td>
<td>□ Mobility – walking</td>
<td>□ Constipation</td>
</tr>
<tr>
<td></td>
<td>□ Exercise/recreation</td>
<td>□ Bloating</td>
</tr>
<tr>
<td></td>
<td>□ Spasm</td>
<td>□ Bladder infection</td>
</tr>
<tr>
<td></td>
<td>□ Other: ________</td>
<td>□ Other: ________</td>
</tr>
<tr>
<td>What makes the pain feel better? **</td>
<td>□ Rest</td>
<td>□ Medications</td>
</tr>
<tr>
<td></td>
<td>□ Position change</td>
<td>□ Distraction</td>
</tr>
<tr>
<td></td>
<td>□ Activity Pacing</td>
<td>□ Exercise</td>
</tr>
<tr>
<td></td>
<td>__________</td>
<td>__________</td>
</tr>
<tr>
<td>What medications or treatments are used?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For your third worst pain, provide the following details:

<table>
<thead>
<tr>
<th>Question</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where is the pain located?</td>
<td></td>
</tr>
<tr>
<td>Is the pain above or below your level of SCI? **</td>
<td>□ Above □ Below</td>
</tr>
<tr>
<td>Is the pain in a region of reduced sensation? **</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>When did the pain start? (Date of onset*)</td>
<td><strong><strong>/</strong></strong>/_______</td>
</tr>
<tr>
<td>Was there an event that triggered the pain?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Details:</td>
<td></td>
</tr>
<tr>
<td>What words best describe your pain? ** (tick all that apply)</td>
<td>□ Aching □ Burning □ Dull □ Icy cold □ Cramping □ Electric Shocks □ Tender □ Pins &amp; Needles □ Squeezing □ Tingling □ Sharp □ Other: ________</td>
</tr>
<tr>
<td>How does pain change over the course of the day?</td>
<td></td>
</tr>
<tr>
<td>What makes the pain feel worse? **</td>
<td>□ Personal care □ Fatigue □ Mobility - transfers □ Stress □ Mobility – wheelchair □ Anxiety □ Mobility – walking □ Constipation □ Exercise/recreation □ Bloating □ Spasm □ Bladder infection □ Other: __________</td>
</tr>
<tr>
<td>What makes the pain feel better? **</td>
<td>□ Rest □ Medications □ Position change □ Distraction □ Activity Pacing □ Exercise □ __________</td>
</tr>
<tr>
<td>What medications or treatments are used?</td>
<td></td>
</tr>
</tbody>
</table>

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