

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Personal Details:

Name:	
Contact Details:	

### Spinal Cord Injury (SCI) Details:

Level of SCI:		Date of SCI:	____ / ____ / ____
Type of SCI:	<input type="checkbox"/> Complete	AIS # (if known) <i>NB: If AIS unknown leave this column blank.</i>	<input type="checkbox"/> A
	<input type="checkbox"/> Incomplete		<input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D

(# 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:

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

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

1. Have you had any pain during the last 7 days including today? *	<input type="checkbox"/> Yes <input type="checkbox"/> 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 <i>(where 0 = no interference and 10 = extreme interference)</i>
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 <i>(where 0 = no interference and 10 = extreme interference)</i>
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 <i>(where 0 = no interference and 10 = extreme interference)</i>
6. Average pain intensity in the past week?	0 1 2 3 4 5 6 7 8 9 10 <i>(where 0 = no pain and 10 = pain as bad as you can imagine)</i>
5. How many different pain problems do you have?*	1 2 3 4 ≥ 5

**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? **	<input type="checkbox"/> Above <input type="checkbox"/> Below
8. Is the pain in a region of reduced sensation? **	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. When did the pain start? (Date of onset*)	____/____/____
10. Was there an event that triggered the pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____
11. What words best describe your pain? ** <i>(tick all that apply)</i>	<input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Dull <input type="checkbox"/> Icy cold <input type="checkbox"/> Cramping <input type="checkbox"/> Electric Shocks <input type="checkbox"/> Tender <input type="checkbox"/> Pins & Needles <input type="checkbox"/> Squeezing <input type="checkbox"/> Tingling <input type="checkbox"/> Sharp <input type="checkbox"/> Other: _____
12. How does pain change over the course of the day?	

\*Questions from the International Spinal Cord Injury Pain Basic Data Set: Version 2 (Widerstrom-Noga et al 2014)

\*\* Questions to help identify SCI Pain Type - International Spinal Cord Injury Pain Classification (Bryce et al 2012)

13. What makes the pain feel worse? **	<input type="checkbox"/> Personal care <input type="checkbox"/> Mobility - transfers <input type="checkbox"/> Mobility – wheelchair <input type="checkbox"/> Mobility – walking <input type="checkbox"/> Exercise/recreation/ sport <input type="checkbox"/> Spasm <input type="checkbox"/> Other: _____	<input type="checkbox"/> Fatigue <input type="checkbox"/> Stress <input type="checkbox"/> Anxiety <input type="checkbox"/> Constipation <input type="checkbox"/> Bloating <input type="checkbox"/> Bladder infection <input type="checkbox"/> Other: _____
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14. What makes the pain feel better? **	<input type="checkbox"/> Rest <input type="checkbox"/> Position/posture change <input type="checkbox"/> Activity Pacing <input type="checkbox"/> _____	<input type="checkbox"/> Medications <input type="checkbox"/> Distraction <input type="checkbox"/> Exercise <input type="checkbox"/> _____
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15. What medications do you use for pain?				
Medication	Dose	Frequency	Helpful?	Side Effects
			<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	

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

17. Treatment Details:

  
  
  
  
  
  
  
  
  
  

Questions marked with \* are from the following source: Widerstrom-Noga, E., Biering-Sorensen, F., Bryce, T.N., Cardenas, D.D., Finnerup, N.B., Jensen, M.P., Richards, J.S., Siddall, P. (2014) International Spinal Cord Injury Pain Basic Dataset (version 2.0), Spinal Cord, 52, pp. 282-286

Questions marked with \*\* reflect information needed to classify SCI pain type based on the following source: Bryce, TN., Biering-Sorensen, F., Finnerup, NB., Cardenas, DD., Defrin, R., Lundeberg, T., Norrbrink, C., Richards, JS., Siddall, P., Stripling, T, Treede, RD., Waxman, SG., Widerstrom-Noga, E., Yezierski, RP., Dijkers, M (2012) The International Spinal Cord Injury Pain Classification: part 1 Background and description, Spinal Cord, 50, pp.413-41

**If you have more than one pain problem, please download the additional pages of the questionnaire and repeat these questions for your 2<sup>nd</sup> and 3<sup>rd</sup> worst pain**



For your second worst pain, provide the following details:

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

For your third worst pain, provide the following details:

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