Pain Management Network

THE SPINAL CORD INJURY PAIN QUESTIONNAIRE

Date: _____/_____/_____

Personal Details:

Name:	
Contact Details:	

Spinal Cord Injury (SCI) Details:

Level of SCI:		**Date of SCI:**	_____/_____/_____
Type of SCI:	☐ **Complete**	**AIS** # *(if known)* *NB: If AIS unknown leave this column blank.*	☐ **A** ☐ **B** ☐ **C** ☐ **D**
	☐ **Incomplete**		

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

For your <u>worst</u> 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 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)*

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13. What makes the pain feel worse? **	☐ Personal care ☐ Mobility - transfers ☐ Mobility – wheelchair ☐ Mobility – walking ☐ Exercise/recreation/ sport ☐ Spasm ☐ Other: _____	☐ Fatigue ☐ Stress ☐ Anxiety ☐ Constipation ☐ Bloating ☐ Bladder infection ☐ Other:_____
14. What makes the pain feel better? **	☐ Rest ☐ Position/posture change ☐ Activity Pacing ☐ _____	☐ Medications ☐ Distraction ☐ Exercise ☐ _____

15. What medications do you use for pain?

Medication	Dose	Frequency	Helpful?	Side Effects
			☐ Y ☐ N	
			☐ Y ☐ N	
			☐ Y ☐ N	
			☐ Y ☐ N	
			☐ Y ☐ 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 dowload the additional pages of the questionnaire and repeat these questions for your 2nd and 3rd worst pain

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For your second worst pain, provide the following details:

Where is the pain located?	_____
Is the pain above or below your level of SCI? **	☐ Above ☐ Below
Is the pain in a region of reduced sensation? **	☐ Yes ☐ No
When did the pain start? (Date of onset*)	_____/_____/_____
Was there an event that triggered the pain?	☐ Yes ☐ No Details:_____
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: _____
How does pain change over the course of the day?	
What makes the pain feel worse? **	☐ Personal care ☐ Fatigue ☐ Mobility - transfers ☐ Stress ☐ Mobility – wheelchair ☐ Anxiety ☐ Mobility – walking ☐ Constipation ☐ Exercise/recreation ☐ Bloating ☐ Spasm ☐ Bladder infection ☐ Other: _____ ☐ Other:_____
What makes the pain feel better? **	☐ Rest ☐ Medications ☐ Position change ☐ Distraction ☐ Activity Pacing ☐ Exercise ☐ _____ ☐ _____
What medications or treatments are used?	

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For your third worst pain, provide the following details:

Where is the pain located?	_____
Is the pain above or below your level of SCI? **	☐ Above ☐ Below
Is the pain in a region of reduced sensation? **	☐ Yes ☐ No
When did the pain start? (Date of onset*)	_____/_____/_____
Was there an event that triggered the pain?	☐ Yes ☐ No Details:_____
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: _____
How does pain change over the course of the day?	
What makes the pain feel worse? **	☐ Personal care ☐ Fatigue ☐ Mobility - transfers ☐ Stress ☐ Mobility – wheelchair ☐ Anxiety ☐ Mobility – walking ☐ Constipation ☐ Exercise/recreation ☐ Bloating ☐ Spasm ☐ Bladder infection ☐ Other: _____ ☐ Other:_____
What makes the pain feel better? **	☐ Rest ☐ Medications ☐ Position change ☐ Distraction ☐ Activity Pacing ☐ Exercise ☐ _____ ☐ _____
What medications or treatments are used?	