Pediatric Pain Medicine
PROGRAM

Parent Pain Questionnaire

Date: ______________ Child's Date of Birth: ______________ Age: ________

Child's Name: ______________ ______________ ______________
(Last) (First) (Middle)

Home Address: ____

____

Home phone #: (____) ____________

What is your preferred contact number? (____) ____________

This questionnaire was completed by: ________________________

Relationship to child: ________________________

Parent's Marital Status: ________________________

Family members living in the home:

Name:	Age:	Relationship:

Other immediate family members not living in the home:

Name:	Age:	Relationship:

INSTRUCTIONS: Please complete this questionnaire independently from your child's.

1) What kind of pain problem does your child have? ________________________

____

____

2) Has your child ever been seen in a pain clinic other than ACH? ____________

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2) In general (or on the average), how much pain do you estimate your child to have? *(circle number)*

0	1	2	3	4	5	6	7	8	9	10
No pain										The worst pain ever

3) How able or confident do you think <u>your child</u> feels about coping with his or her pain? *(circle number)*

0	1	2	3	4	5	6	7	8	9	10
Not at all able to cope										Extremely able to cope

4) a) List all the medications (include doses, if known) that your child <u>currently</u> takes for pain. ______________

____

____

b) How helpful is medicine for your child's pain? *(Circle number)*

0	1	2	3	4	5	6	7	8	9	10
Does not help pain at all										Completely takes pain away

c) What medications has your child tried <u>in the past</u> and how helpful were they? (Please list doses, if known, and approximately how long ago or when they were tried.) ______________

____

____

____

5) Has your child seen other physicians for his or her pain? *(Circle)* Yes No

a) If *yes*, which doctor(s) and where? ______________

____

____

b) What is your understanding of the doctors' explanation of the pain problem <u>*or*</u> what have you been told about your child's pain? ______________

____

____

6) Has your child had physical therapy to treat his or her pain? *(Circle)* Yes No
If *yes*:

a) Where do you go for physical therapy? ______________

b) How many times a week? ______________

c) When did you first start? ______________

7) What other treatment or therapies has your child had to treat pain or symptoms relating to pain? (e.g. counseling, acupuncture, massage therapy, chiropractic treatment, etc.) ______________

____

____

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8) Has your child's appetite changed? *(circle)* Yes No

If yes, has it: ☐ increased ☐ decreased

9) Has your child gained weight (More weight than expected for normal growth)? *(circle)* Yes No

If yes, how much? ________________

10) Has your child lost weight? *(circle)* Yes No

If yes, how much? ________________

11) Child's School: ______________________________ Grade: ________

Special Classes (advanced or remedial): *(circle)* Yes No

If yes, please describe: ____

____

____

Child's typical grades: ______________________________________

12) To what degree has your child's pain affected or changed your family? *(circle number)*

0 1 2 3 4 5 6 7 8 9 10

Has not affected or changed — **Has significantly affected or changed**

Please describe: ____

13) To what degree has your child's pain problem interfered with his/her school attendance? *(circle number)*

0 1 2 3 4 5 6 7 8 9 10

Has not interfered at all — **Has significantly interfered**

Number of school days missed in last four weeks: ________________

14) To what degree has your child's pain interfered with his/her social activity (playing or going out with friends)? *(circle number)*

0 1 2 3 4 5 6 7 8 9 10

Has not interfered at all — **Has significantly interfered**

15) To what degree has your child's pain stopped your child from playing sports or taking Physical Education? *(circle number)*

0 1 2 3 4 5 6 7 8 9 10

Has not stopped at all — **Has stopped completely**

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16) How do you think the pain clinic will or can help your child? ______________________

____

____

____

17) How optimistic are you about your child's pain getting better? *(circle number)*

0 1 2 3 4 5 6 7 8 9 10

Not at all likely to get better — **Very likely to get better**

18) Is there anything else we should know about your child's pain that we haven't asked? ______________

____

____

19) Is there anything else we should know about your child? (e.g., diagnoses such as ADD / concerns about depression, anxiety, developmental delay, or cognitive impairment)

If yes, please describe: ______________________________

____

____

20) Is there anything else that would be important to know about your family (e.g. financial difficulties, recent or ongoing stress such as a divorce, separation, or death in the family)? ______________

____

____

____

____

21) Do any family members have pain problems? *(circle)* Yes No

If yes, please describe: ______________________________

____

____

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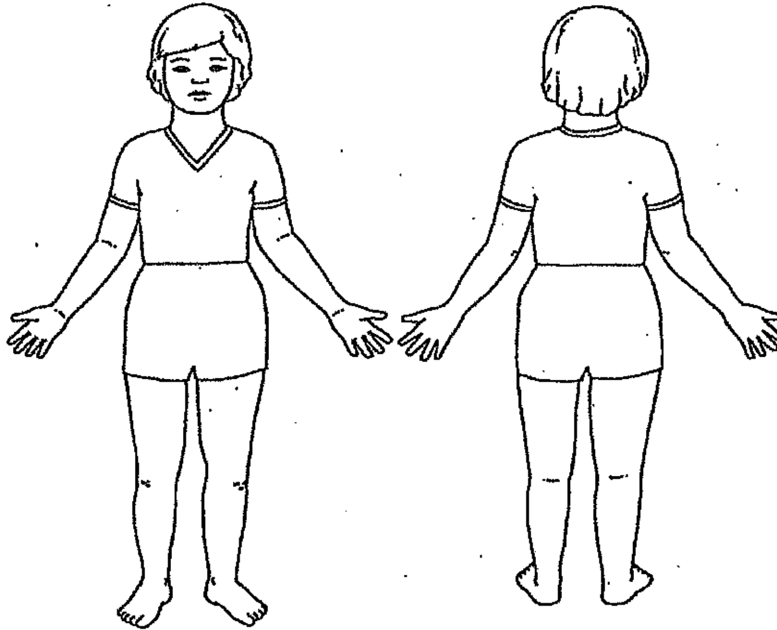
The following questions were included in your child's questionnaire. Therefore, it is not necessary to complete the following section, unless you prefer to do so.

If your child does not complete a questionnaire, however, please continue so that we may have the following information

22) Shade in where on your child's body his or her pain is.



a) When did your child's pain first start? (month, year) ______________________

b) What was your child doing when his or her pain first began or when it was first noticed?

____

____

22) Does your child's pain move or spread to another part of his/her body from where it first starts? *(Circle)* **Yes No**

If yes, from where to where? ______________________

____

24) What time of day is your child's pain worst? ______________________

25) Do any of the following make your child's pain worse?

Coughing, sneezing?	☐ yes	☐ no
Sitting	☐ yes	☐ no
Standing	☐ yes	☐ no
Lying down	☐ yes	☐ no
Walking	☐ yes	☐ no
Physical activity	☐ yes	☐ no
Other (describe) ____________	☐ yes	☐ no

Comments/Additional Information: ______________________

____

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26) Do any of the following make your child's pain better?

Relaxation	☐ yes	☐ no
Sitting	☐ yes	☐ no
Standing	☐ yes	☐ no
Lying down	☐ yes	☐ no
Heat	☐ yes	☐ no
Cold	☐ yes	☐ no
Medicines	☐ yes	☐ no
Walking	☐ yes	☐ no
Other (describe) ______________	☐ yes	☐ no

Comments/Additional Information: ____

____

27) Does your child have:

			If yes, where on his/her body?
Numbness?	☐ yes	☐ no	______________________
Tingling, pins and needles?	☐ yes	☐ no	______________________
Weakness?	☐ yes	☐ no	______________________
Increased sweating?	☐ yes	☐ no	______________________
Muscle spasms, tightness?	☐ yes	☐ no	______________________

28) Does pain make it difficult for your child to fall asleep? *(Circle)* Yes No

If *yes*, how often? ____

29) Does pain wake your child up in the middle of the night after he or she is asleep? *(circle)* Yes No

30) Since your child's pain started, has it, in general:

1) ☐ increased 2) ☐ decreased 3) ☐ stayed the same

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