EXTERNAL REFERRAL FORM

Michael G. DeGroote PAIN CLINIC

Hamilton Health Sciences

For quick access to pain services, please consider the following:

- Referral to a pain specialist via https://econsultontario.ca to have pain related questions answered within days by a pain specialist.
- Referral to free pain resources, courses, and peer support via https://poweroverpain.ca
- Determine if your patient has coverage for private health benefits for rehabilitation therapies (e.g., physiotherapy, occupational therapy, psychotherapy) to help cope with their chronic pain problem.

Please review the following:

Patients referred to the Michael G. DeGroote (MGD) Pain Clinic must have a Primary Care Provider (PCP), who is **expected to play an active role in the treatment of their patient**. When completing this referral, please include **all information in the form where indicated**. Missing information will result in triaging and booking delays for your patient.

Referrals will be reviewed and if accepted your patient may receive a medical consultation from a physician/nurse practitioner as well as consultation from other healthcare providers in our interprofessional team.

Initial beside each statement, if in agreement:

☐ I understand that MGD physicians and nurse practitioners will **NOT** take over prescribing permanently for my patient.

☐ I understand that in cases where treatment is initiated by the MGD Pain Clinic, once stabilized (6-24 months) the patient will be returned to the PCP for ongoing care, **including pharmacotherapy prescribing, with our continued support.**

If not in agreement, please provide rationale:

Referrer Name: **Patient Name:** **Date:**

Referrer Signature:

REFERRAL INCOMPLETE WITHOUT SIGNATURE

EXTERNAL REFERRAL FORM

PATIENT:

Michael G. DeGroote PAIN CLINIC

Hamilton Health Sciences

SECTION A - REFERRING PROVIDER INFORMATION

REFERRING PROVIDER:

EMAIL:

ADDRESS:

PHONE:

FAX:

DO YOU BELONG TO A FAMILY HEALTH TEAM? Yes

PRIMARY CARE PROVIDER (PCP) INFORMATION (IF DIFFERENT THAN ABOVE)

PCP NAME:

PCP LICENSE#:

PCP PHONE:

PCP FAX:

SECTION B - REFERRAL INFORMATION

NEW REFERRAL

RE-REFERRAL (must provide reason below):

TREATMENT SOUGHT

INTERVENTION (If yes, go to **section G on page 5**)

MEDICATION CONSULTATION

GROUP EDUCATION

WHEN DID THE PAIN START?: Less than 3 months ago 3-6 months ago More than 6 months ago

DOES THE PATIENT HAVE ACTIVE CANCER OR ARE THEY DEEMED PALLIATIVE? Yes

DOES THE PATIENT HAVE ANY OF THE FOLLOWING PAIN CONDITIONS?:

CRPS Back Pain Lumbar Radicular Pain Cervical Neck Pain

IS THE PATIENT A CANADIAN ARMED FORCES VETERAN?: Yes

HAS THE PATIENT HAD A WORKPLACE INJURY OR MOTOR VEHICLE ACCIDENT (MVA) IN THE PAST 5 YEARS?: Yes

EXTERNAL REFERRAL FORM

PATIENT:

Michael G. DeGroote PAIN CLINIC

Hamilton Health Sciences

SECTION C - PATIENT DEMOGRAPHICS

FIRST NAME:		MIDDLE NAME:	
SURNAME:		PREFERRED NAME:	
OHIP #:	VERSION:	DOB (DD/MM/YYYY):	
SEX:	GENDER:	PRONOUNS:	
STREET ADDRESS:			
CITY:	PROVINCE: ON	POSTAL CODE:	
HOME PHONE:	CELL PHONE:	EMAIL:	HEIGHT: / WEIGHT:

PREFERRED LANGUAGE: ☐ ENGLISH ☐ OTHER: ☐ INTERPRETER REQUIRED?

SECTION D - CURRENT AND PAST TREATMENTS

CONSERVATIVE

☐ Acupuncture ☐ Chiropractic ☐ Dietitian ☐ Occupational Therapy ☐ Physiotherapy

☐ Psychology ☐ Social Work ☐ Naturopath/Homeopath/Osteopath

INTERVENTIONAL

☐ Epidural ☐ Intra-articular Injections ☐ Infusions ☐ Nerve Blocks ☐ Surgery

☐ Other (please specify):

MEDICATION (*Please complete or fax list – if no information provided, referral will be returned***)**

	Current	Past	Not tried	Unknown	Response/Adverse Effects
gabapentin (Neurontin) / pregabalin (Lyrica)	☐	☐	☐	☐	
duloxetine (Cymbalta)	☐	☐	☐	☐	
amitriptyline (Elavil) / other TCA	☐	☐	☐	☐	
NSAIDs	☐	☐	☐	☐	
Opioids	☐	☐	☐	☐	
Cannabis / nabilone (Cesamet)	☐	☐	☐	☐	

Other (Please specify):

EXTERNAL REFERRAL FORM

PATIENT:

Michael G. DeGroote PAIN CLINIC

Hamilton Health Sciences

SECTION E - PAIN INFORMATION (SELECT ALL THAT APPLY)

☐ **Abdominal Pain**

☐ Chronic Pancreatitis ☐ Functional Abdominal ☐ Inflammatory Bowel Disease

☐ Post Surgical ☐ Irritable Bowel Syndrome ☐ Other:

GI specialist consultation?: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

☐ **Headache (Please go to Section G to request specific intervention)**

☐ Acquired Brain Injury ☐ Cervicogenic Headache ☐ Occipital Neuralgia

☐ Migraine, Cluster, or Tension Headache ☐ Other:

Neurology consultation?: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

Head/neck MRI or CT in past 2 years?: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

☐ **Musculoskeletal Pain (Please go to Section G to request specific intervention)**

☐ Neck Pain - **Cervical MRI** in the past 2 years?: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

☐ Upper/Mid Back Pain - **Thoracic MRI** in the past 2 years?: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

☐ Low Back Pain - **Lumbosacral MRI** in the past 2 years?: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

☐ Joint/Limb pain - Indicate Joint(s) or Limb(s):

☐ **Neuropathic Pain (Please go to Section G to request specific intervention)**

☐ Complex Regional Pain Syndrome ☐ Multiple Sclerosis ☐ Painful Diabetic Neuropathy

☐ Phantom Limb Pain ☐ Post Stroke Pain ☐ Post Herpetic Neuralgia

☐ Trigeminal Neuralgia ☐ Post Surgical /Post Traumatic (Specify location below):

☐ Other:

Neurology consultation?: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

EMG testing?: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

☐ **Pelvic Pain**

☐ Chronic Pelvic Pain ☐ Endometriosis ☐ Interstitial Cystitis ☐ Post-Surgical/-Traumatic

☐ Other:

BGYN or Urology consultation?: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

☐ **Rheumatological Pain**

☐ Fibromyalgia ☐ Lupus ☐ Polymyalgia Rheumatica ☐ Rheumatoid Arthritis

☐ Sjogren's Syndrome ☐ Other:

Rheumatology consultation?: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

EXTERNAL REFERRAL FORM

PATIENT:

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Hamilton Health Sciences

SECTION F - PSYCHIATRIC DIAGNOSES

- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Posttraumatic Stress Disorder
- ☐ Bipolar Disorder
- ☐ Personality Disorder
- ☐ Insomnia
- ☐ ADHD
- ☐ Psychosis/Schizophrenia
- ☐ Eating Disorder
- ☐ Autism Spectrum Disorder
- ☐ Substance Use Disorder (specify):
  - ☐ Alcohol
  - ☐ Opioids
  - ☐ Cannabis
  - ☐ Other:

SECTION G - REQUEST FOR SPECIFIC INTERVENTIONAL TREATMENT

Head and Neck Pain

Please select all that apply: ☐ Head Dominant ☐ Limb Dominant ☐ Facial Dominant ☐ Neck Dominant ☐ Whiplash Associated Disorder

Radicular features? ☐ Yes ☐ No ☐ Unknown

Specific request for **head/neck** intervention:

Low Back Pain

Please select all that apply: ☐ Back Dominant ☐ Limb dominant ☐ Non-Mechanical back pain ☐ SI Joint Dominant ☐ Failed back surgery syndrome

Radicular features? ☐ Yes ☐ No ☐ Unknown

Specific request for **head/neck** intervention:

Other region/limb/joint pain, please specify intervention:

SECTION H – SUPPLEMENTAL FORMS AND DOCUMENTS – PLEASE ATTACH

Submit the following imaging relevant to pain problem: ☐ **Ultrasound** ☐ **CT** ☐ **ED CHART** ☐ **MRI** ☐ **EMG**

Please have your patient complete the following measures and fax back with referral form:

☐ **painDETECT**	☐ **Pain Disability Index**	☐ **PHQ-4**	☐ **PCS**	☐ **TSK**	☐ **PSEQ**

Patient Self Report Package

FIRST NAME:	**MIDDLE NAME:**
LAST NAME:	**PREFERRED NAME:**

SEX: ☐ Male ☐ Female | **GENDER:** ☐ Man ☐ Woman ☐ Specify: | **PRONOUNS:**

DOB: / / dd / mm / yyyy	**HEIGHT:**	**WEIGHT:**
Ethnic Background/Race:	**Languages Spoken:** ☐ Interpreter Required ☐ English ☐ French ☐ Other:	

Religious Background

☐ Atheist ☐ Agnostic ☐ Buddhist ☐ Christian → Denomination
☐ Hindu ☐ Jewish ☐ Muslim ☐ Sikh ☐ Other:

Marital Status

☐ Common Law/Partner ☐ Divorced ☐ Legally Separated ☐ Married
☐ Significant Other ☐ Single ☐ Unknown ☐ Widowed ☐ Other:

Highest Education Level

☐ Elementary school ☐ Some high school ☐ High school diploma/GED
☐ Some college or university ☐ College degree ☐ Bachelor's Degree ☐ Masters Degree
☐ Ph.D. ☐ Professional Degree (e.g. MD, DDS, JD, PharmD)

Employment Status (Check all that apply)

☐ Never employed ☐ Student ☐ Part time ☐ Full Time ☐ Self-employed
☐ Retired ☐ CPP/Disability ☐ ODSP ☐ Ontario Works ☐ WSIB
☐ Short term disability ☐ Long term disability ☐ Other:

If you were employed, or currently employed, please describe your job and how many years you have worked:

Who do you live with? (Check all that apply)

☐ Live alone ☐ Spouse/Partner ☐ Child(ren) ☐ Parent(s) ☐ Grandparent(s)
☐ Grandchild(ren) ☐ Roommate/friend ☐ Pet(s) ☐ Other:

What type of residence do you live in?

☐ Single floor house/Townhouse/Condo ☐ Multistory House/Townhouse/Duplex
☐ Multistory Apartment/Condo Building → Does this building have an elevator? ☐ Yes ☐ No
☐ Other:

Please describe any family history of medical conditions:

Mother:	Father:
Maternal Grandmother:	Paternal Grandmother:
Maternal Grandfather:	Paternal Grandfather:
Sister(s):	Brother(s):
Aunts:	Uncles:
Children:	

What pain and other symptoms are you experiencing?

- ☐ Numbness
- ☐ Weakness
- ☐ Swelling
- ☐ Stiffness
- ☐ Hot-Burning
- ☐ Dull
- ☐ Tender
- ☐ Shooting
- ☐ Aching/Throbbing
- ☐ Sharp/Stabbing
- ☐ Cramping
- ☐ Itching

☐ Other (please explain):

Which of the above symptoms is the worst?

Where do you have the most pain?

When did your pain symptoms start?

Did your pain symptoms start ☐ suddenly or ☐ gradually?

What caused your pain problem(s)?

- ☐ Work Accident/Injury
- ☐ Motor Vehicle Collison
- ☐ Fall
- ☐ Disease related (please explain):
- ☐ After Surgery
- ☐ Unknown
- ☐ Other (please explain):

What makes your symptoms worse?

- ☐ Lying in Bed
- ☐ Standing
- ☐ Walking
- ☐ Sitting
- ☐ Driving
- ☐ Squatting
- ☐ Kneeling
- ☐ Bending
- ☐ Stairs
- ☐ Pushing/Pulling
- ☐ Getting out of bed/chair
- ☐ Lifting
- ☐ Sports/Exercise
- ☐ Stress
- ☐ Weather
- ☐ Other (please explain):

What makes your symptoms better?

- ☐ Ice
- ☐ Heat
- ☐ Elevation
- ☐ Massage
- ☐ Acupuncture
- ☐ TENS
- ☐ Medications:
- ☐ Other:
- ☐ Inophoresis
- ☐ Physiotherapy
- ☐ Occupational Therapy
- ☐ Yoga
- ☐ Chiropractor
- ☐ Osteopath
- ☐ Braces/Splints
- ☐ Naturopath/Herbal
- ☐ Psychotherapy/Counselling
- ☐ Meditation/Mindfulness
- ☐ Prayer/Spirituality

Please list any allergies:

List any other medical issues you have, besides pain:

List any other medical surgeries/procedures/injections you have had in the past and when:

Sleep

Do you have difficulty falling asleep? ☐ Never ☐ Rarely ☐ Sometimes ☐ Every Night

If so, how long does it take you to get to sleep?

Do you have difficulty staying asleep? ☐ Never ☐ Rarely ☐ Sometimes ☐ Every Night

If so, what causes you to wake up?

How often do you wake up per night?

Do you use a CPAP machine for sleep apnea? ☐ NA ☐ Never ☐ Rarely ☐ Sometimes ☐ Every Night

Stop-Bang Questionnaire

☐ Yes ☐ No	**S**noring	Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?
☐ Yes ☐ No	**T**ired	Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling asleep during driving or talking to someone)?
☐ Yes ☐ No	**O**bserved	Has anyone **Observed** you **Stop Breathing** or **Choking/Gasping** during your sleep?
☐ Yes ☐ No	**P**ressure	Do you have or are being treated for **High Blood Pressure** ?
☐ *Yes* ☐ *No*	***B**MI*	*Body mass index > 35 (for office use)*
☐ Yes ☐ No	**A**ge	Are you older than 50?
☐ Yes ☐ No	**N**eck	Is your neck size large (shirt collar 16 in or 40 cm or larger)
☐ Yes ☐ No	**G**ender	Are you male?

For office use:
OSA - Low Risk : Yes to 0 - 2 questions
OSA - Intermediate Risk : Yes to 3 - 4 questions
OSA - High Risk : Yes to 5 - 8 questions
or Yes to 2 or more of 4 STOP questions + male gender
or Yes to 2 or more of 4 STOP questions + BMI > 35kg/m2
or Yes to 2 or more of 4 STOP questions + neck circumference 16 inches / 40cm

<u>Social History</u>

Do you drink alcohol ? ☐ Yes ☐ No

If so, how many drinks per week do you drink?

What is the most you would drink in one day?

Do you drink caffeine (coffee, tea, cola, energy drinks) ? ☐ Yes ☐ No

If so, how many cups/drinks per day?

Do you smoke tobacco?

☐ Yes, currently → How many cigarettes/day for years

☐ No, but I used to→ How many cigarettes/day for years. I quit years ago

☐ No, but I vape tobacco

☐ Never

Do you use cannabis?

☐ No

☐ Yes, recreational use

☐ Yes, medical use

If you said yes, how do you consume cannabis: ☐ Smoke ☐ Vape ☐ Oral ☐ Topical

What type of cannabis do you use? : ☐ Mainly THC ☐ Mainly CBD ☐ A balance of CBD/THC

Do you use illicit drugs? ☐ Yes, often ☐ Yes, but rarely ☐ No, but in the past I did ☐ Never

What illicit drug did you/do you use?

PDQ

How would you assess your pain **now**, at this moment?

0 1 2 3 4 5 6 7 8 9 10

How strong was the **strongest** pain during the past 4 weeks?

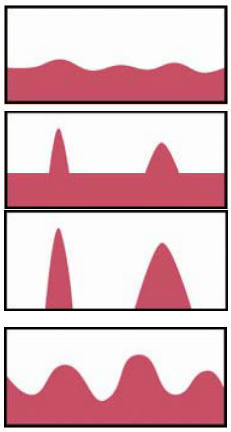
0 1 2 3 4 5 6 7 8 9 10

How strong was the pain during the past 4 weeks on **average**?

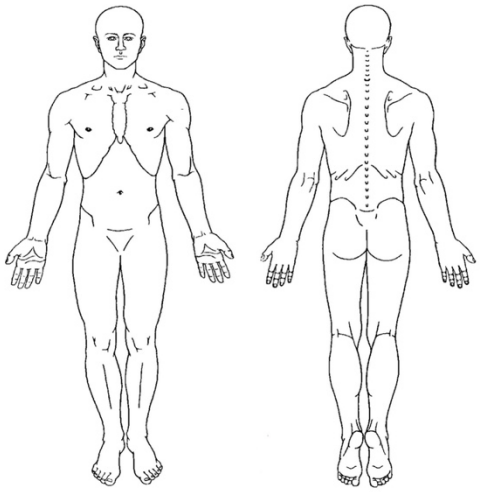
0 1 2 3 4 5 6 7 8 9 10

Mark the picture that best describe the course of your pain

1. Persistent pain with slight fluctuations ☐
2. Persistent pain with pain attacks ☐
3. Pain attacks without pain between them ☐
4. Pain attacks with pain between them ☐



Please mark your **main area** of pain



5. Does your pain radiate to other regions of your body?

☐ Yes - draw the direction where the pain radiates to

☐ No

	Never	Hardly Noticed	Slightly	Moderately	Strongly	Very Strongly
Do you suffer from a burning sensation (e.g., like stinging nettles) in the marked areas?	☐	☐	☐	☐	☐	☐
Do you have a tingling or prickling sensation in the area of your pain (like crawling ants or electrical tingling)?	☐	☐	☐	☐	☐	☐
Is light touching (with clothing, or a blanket) in this area painful?	☐	☐	☐	☐	☐	☐
Do you have sudden pain attacks in the area of your pain, like electric shocks?	☐	☐	☐	☐	☐	☐
Is cold or heat (bath water) in this area occasionally painful?	☐	☐	☐	☐	☐	☐
Do you suffer from a sensation of numbness in the areas that you marked?	☐	☐	☐	☐	☐	☐
Does slight pressure in this area, e.g., with a finger, trigger pain?	☐	☐	☐	☐	☐	☐
FOR OFFICE CODING	x 0 =	x 1 =	x 2 =	x 3 =	x 4 =	x 5 =
					SUBTOTAL	
-1 IF IMAGE 2 MARKED; **+1** IF IMAGE 3 OR 4 MARKED; **+2** IF YES TO RADIATING PAINS					**FINAL**	

NOCICEPTIVE – 0-12; **UNCLEAR/MIXED** – 13-18; **NEUROPATHIC** (>90% LIKELIHOOD) – 19-38

Development/Reference: R. Freynhagen, R. Baron, U. Gockel, T.R. Tölle / Curr Med Res Opin, Vol.22, No. 10 (2006)

PHQ-4

Over the last 2 weeks, how often have you been bothered by the following problems?

		Not at all	Several Days	More than half the days	Nearly every day	
1	Feeling nervous, anxious or on edge	0	1	2	3	
2	Not being able to stop or control worrying	0	1	2	3	
3	Little interest or pleasure in doing things	0	1	2	3	
4	Feeling down, depressed, or hopeless	0	1	2	3	
FOR OFFICE CODING - **TOTAL**						

Development/Reference: Kroenke K, Spitzer RL, Williams JB, Löwe B. An ultra-brief screening scale for anxiety and depression: the PHQ-4. Psychosomatics. 2009;50(6):613-21. From Principles of Neuropathic Pain Assessment and Management, November 2011.

PDI

The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, **please circle the number on the scale** that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

	No Disability										Worst Disability	
Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).	0	1	2	3	4	5	6	7	8	9	10	
Recreation: This disability includes hobbies, sports, and other similar leisure time activities.	0	1	2	3	4	5	6	7	8	9	10	
Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.	0	1	2	3	4	5	6	7	8	9	10	
Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.	0	1	2	3	4	5	6	7	8	9	10	
Sexual Behavior: This category refers to the frequency and quality of one's sex life.	0	1	2	3	4	5	6	7	8	9	10	
Self Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)	0	1	2	3	4	5	6	7	8	9	10	
Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.	0	1	2	3	4	5	6	7	8	9	10	
											FOR OFFICE CODING - **TOTAL**	

References: Chibnall JT Tait RC. The Pain Disability Index: Factor Structure and Normative Data. Arch Phys Med Rehabil. 1994; 75: 1082-1086. Pollard CA. Preliminary validity study of the pain disability index. Perceptual and Motor Skills. 1984; 59: 974. Tait RC Chibnall JT Krause S. The pain disability index: psychometric properties. Pain. 1990; 40: 171-182.

TSK

Please read each of the following statements and circle the number that better represents your feelings

		Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
1	I'm afraid that I might injure myself if I exercise	1	2	3	4
2	If I were to try to overcome it, my pain would increase	1	2	3	4
3	My body is telling me I have something dangerously wrong	1	2	3	4
4	People aren't taking my medical condition seriously enough	1	2	3	4
5	My accident has put my body at risk for the rest of my life	1	2	3	4
6	Pain always means I have injured my body	1	2	3	4
7	Simply being careful that I do not make any unnecessary movements is the safest thing I can do to prevent my pain from worsening	1	2	3	4
8	I wouldn't have this much pain if there weren't something potentially dangerous going on in my body	1	2	3	4
9	Pain lets me know when to stop exercising so that I don't injure myself	1	2	3	4
10	I can't do all the things normal people do because it's too easy for me to get injured	1	2	3	4
11	No one should have to exercise when he/she is in pain	1	2	3	4
	FOR OFFICE CODING - **TOTAL**				

Reference: Vlaeyen, J. W. S., Kole-Snijders, A. M. J., Boeren, R. G. B., & Van Eek, H. (1995). Fear of movement/(re) injury in chronic low back pain and its relation to behavioral performance. Pain, 62(3), 363-372.

PCS

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

Instructions:

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

		Not at all	To a slight degree	To a moderate degree	To a great degree	All the time	
1	I worry all the time about whether the pain will end.	0	1	2	3	4	
2	I feel I can't go on.	0	1	2	3	4	
3	It's terrible and I think it's never going to get any better	0	1	2	3	4	
4	It's awful and I feel that it overwhelms me.	0	1	2	3	4	
5	I feel I can't stand it anymore	0	1	2	3	4	
6	I become afraid that the pain will get worse.	0	1	2	3	4	
7	I keep thinking of other painful events	0	1	2	3	4	
8	I anxiously want the pain to go away	0	1	2	3	4	
9	I can't seem to keep it our of my mind	0	1	2	3	4	
10	I keep thinking about how much it hurts.	0	1	2	3	4	
11	I keep thinking about how badly I want the pain to stop	0	1	2	3	4	
12	There's nothing I can do to reduce the intensity of the pain	0	1	2	3	4	
13	I wonder whether something serious may happen.	0	1	2	3	4	
	FOR OFFICE CODING - **TOTAL**						

Development and validation. Sullivan, M.J.L., Bishop, S.R., Pivik, J. (1995)Psychological Assessment; 7: 524-532

PSEQ

Please rate how **confident** you are that you can do the following things at present, **despite the pain**. To indicate your answer circle one of the numbers on the scale under each item, where 0 = not at all confident and 6 = completely confident.

Remember, this questionnaire is not asking whether of not you have been doing these things, ***but rather how confident you are that you can do them at present, despite the pain.***

		Not Confident at All						**Completely Confident**
1	I can enjoy things, despite the pain.	0	1	2	3	4	5	6
2	I can do most of the household chores (e.g. tidying-up, washing dishes, etc.), despite the pain.	0	1	2	3	4	5	6
3	I can socialise with my friends or family members as often as I used to do, despite the pain.	0	1	2	3	4	5	6
4	I can cope with my pain in most situations.	0	1	2	3	4	5	6
5	I can do some form of work, despite the pain. ("work" includes housework, paid and unpaid work).	0	1	2	3	4	5	6
6	I can still do many of the things I enjoy doing, such as hobbies or leisure activity, despite pain.	0	1	2	3	4	5	6
7	I can cope with my pain without medication.	0	1	2	3	4	5	6
8	I can still accomplish most of my goals in life, despite the pain	0	1	2	3	4	5	6
9	I can live a normal lifestyle, despite the pain.	0	1	2	3	4	5	6
10	I can gradually become more active, despite the pain.	0	1	2	3	4	5	6
	FOR OFFICE CODING - **TOTAL**							

Development: Nicholas, M. K. (2007). The pain self-efficacy questionnaire: Taking pain into account. European Journal of Pain, 11(2), 153-163.