NORTHSHORE INTEGRATIVE HEALTHCARE

Phone: 847-920-4NIH (4644) www.NorthshoreIntegrativeHealthcare.com

Patient Information Packet

Name: _____Phone# _____

1. Age _____ years Date of Birth: Month _____ Day _____ Year _____
2. Gender _____ Female _____ Male
3. Height _____ feet _____ inches Weight _____ (Lbs)
4. Marital status:
   _____ Married
   _____ Single
   _____ Divorced
   _____ Seperated
   _____ Widowed
5. Race
   _____ Black
   _____ Asian
   _____ White
   _____ Hispanic
   _____ Other
6. Is English your first/native language? _____ Yes _____ No. If no, then what is? _____
7. What is your highest level of education? _____ years.
8. Where is your pain located? _____
9. How long have you had the pain for which now you are seeking treatment?
   _____ Years _____ Months
10. Are you currently working?
    _____ Yes _____ No
11. If yes, how many hours per week?
    _____ Hours
12. If not working because of pain, how long have you been out of work? _____(months)
13. Were you injured at work?
    _____ Yes _____ No
14. Is there an attorney involved in your case?
    _____ Yes _____ No
15. Is your case currently in the courts?
    _____ Yes _____ No
16. Are you receiving Workers Compensation?
    _____ Yes _____ No
17. When did your pain begin? (Be as specific as possible). _____
18. Please indicate the one statement that best describes you.
    _____ 1. Working full-time
    _____ 2. Working part-time
    _____ 3. Retired
    _____ 4. Unemployed
    _____ 5. Retired early because of pain
    _____ 6. Not working because of pain
    _____ 7. Working part-time because of pain
    _____ 8. Homemaker
19. Under what circumstances did your pain begin? Please check one.
    _____ 1. Accident at work
    _____ 2. Accident at home
    _____ 3. Motor vehicle accident
    _____ 4. Following illness
    _____ 5. Following surgery
    _____ 6. Unknown
    _____ 7. Other (Specify) _____

20. Do you receive any other type of compensation because of your pain/health problem?
    _____ 1. Social Security Disability _____ 2. Other (Please specify)

21. How many pain-relarted surgeries have you had? _____

22. Not including your current visit, how many times have you seen a physician in the past six (6) months for your pain problem? _____

23. Over the past six (6) months, how many times have you gone to the emergency room for your pain problem? _____

24. How many different doctors have seen you for your pain? _____

25. How many days have you been hospitalized in the past six (6) months because of pain? _____

26. On a typical day during the past week, how many hours did you spend standing, walking, or sitting in an upright position engaged in a productive activity? _____ hours/day.

27. What is the intyensity of your pain right now?

    No pain 0 1 2 3 4 5 6 7 8 9 10 Worse pain possible

28. What is the intensity of the pain you usually experience?

    No pain 0 1 2 3 4 5 6 7 8 9 10 Worse pain possible

29. What was the lowest intensity of your pain during the past week?

    No pain 0 1 2 3 4 5 6 7 8 9 10 Worse pain possible

30. What was the highest intensity of your pain during the past week?

    No pain 0 1 2 3 4 5 6 7 8 9 10 Worse pain possible

PREVIOUS MEDICAL TREATMENT

Have you had any of the following conditions?

- ☐ Epilepsy, Seizures
- ☐ Thyroid disease
- ☐ Jaundice or liver disease
- ☐ Psychiatric disorder
- ☐ Tuberculosis
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Bladder problems
- ☐ Bowel problems
- ☐ Hearing problems
- ☐ Visual problems
- ☐ Bronchitis, Asthma, other lung disease
- ☐ Stroke
- ☐ Diabetes
- ☐ Ulcers, other stomach problems
- ☐ Skin rash
- ☐ Joint disease, Arthritis
- ☐ Allergies_____
- ☐ Other _____

Approximately how many times a year did you visit a physician for any reason prior to your pain problem? _____

Since your pain problem, approximately how many times a year do you visit a physician for any reason? _____

What surgeries have you had for health problems not related to your pain problem? _____
_____
_____

PERCEIVED DISABILITY SCALE

INSTRUCTIONS: Circle the number that describes your current level of disability.

1) Home Activities: includes active things you do around your home, including making the bed, cooking, cleaning (dusting, vacuuming, dishes, laundry, floors), shopping, yard work, etc.

NO Disability 0 1 2 3 4 5 6 7 8 9 10 Total Disability

2) Passive Recreation Activity: activities done alone or with others such as hobbies, puzzles, knitting, dining out, going to movies, social functions (do not include watching TV)

NO Disability 0 1 2 3 4 5 6 7 8 9 10 Total Disability

3) Active, Physical Activity: activities done alone or with others that are sport or exercise in nature, such as long walks, jogging, swimming, bicycling, golfing, bowling, tennis, etc.

NO Disability 0 1 2 3 4 5 6 7 8 9 10 Total Disability

4) Occupational and/or Education: includes physical and cognitive activities related to working at your job, school, volunteer work, etc.

NO Disability 0 1 2 3 4 5 6 7 8 9 10 Total Disability

5) Self Care: includes activities of daily living such as bathing, brushing your teeth, getting dressed, going to the bathroom, combing your hair, shaving, moving about your home, etc.

NO Disability 0 1 2 3 4 5 6 7 8 9 10 Total Disability

6) Basic Life Activities: includes eating, drinking, and breathing

NO Disability 0 1 2 3 4 5 6 7 8 9 10 Total Disability

7) Sleep: includes your ability to fall asleep, stay asleep, and feel rested in the morning

NO Disability 0 1 2 3 4 5 6 7 8 9 10 Total Disability

8) Sexual Behavior: includes the quality (frequency, ability, pleasure, etc.) of your sex life

NO Disability 0 1 2 3 4 5 6 7 8 9 10 Total Disability

9) Thinking: refers to memory, attention, concentration, problem solving, understanding, etc.

NO Disability 0 1 2 3 4 5 6 7 8 9 10 Total Disability

10) Social: refers to maintaining or developing relationships with family, friends, or others

NO Disability 0 1 2 3 4 5 6 7 8 9 10 Total Disability

MULTIDIMENSIONAL PAIN INVENTORY

(© Kerns, Turk, & Rudy, 1985)

NAME _____ DATE _____

INSTRUCTIONS: Please read each question carefully and then do your best to answer each one. **Do not skip any questions.** If there is a question that you think does not apply to you, please **circle the number** of that question.

A. Some of the questions in this questionnaire refer to your "significant other." A significant other is a person with whom you feel closest. This includes anyone that you relate to on a regular or infrequent basis.

□ Spouse □ Partner/Companion □ Housemate/Roommate
□ Friend □ Neighbor □ Parent/child/other relative
□ Other (please describe): _____

B. Do you currently live with this person? □ YES □ NO

EXAMPLE : How nervous are you when you ride in a car when the traffic is heavy?

Not at all nervous 0 1 2 3 4 5 6 Extremely nervous

If you are not at all nervous when riding in a car in heavy traffic, you would want to **circle** the number 0. If you are very nervous when riding in a car in heavy traffic, you would then **circle** the number 6. Lower numbers would be used for less nervousness, and higher numbers for more nervousness.

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Rate the level of your pain at the **present moment.**

No pain 0 1 2 3 4 5 6 Very intense pain

2. In general, how much does your pain interfere with your day-to-day activities?

No interference 0 1 2 3 4 5 6 Extreme interference

3. Since the time your pain began, how much has your pain changed your ability to work? (____Check here if you are not working for reasons other than your pain).

No change 0 1 2 3 4 5 6 Extreme change

4. How much has your pain changed the amount of satisfaction or enjoyment you get from taking part in social and recreational activities?

No change 0 1 2 3 4 5 6 Extreme change

5. How supportive or helpful is your significant other (this refers to the person you indicated above) to you in relation to your pain?

Not at all supportive 0 1 2 3 4 5 6 Extremely supportive

6. Rate your overall mood during the past week.

Extremely low 0 1 2 3 4 5 6 Extremely high

7. How much has your pain interfered with your ability to get enough sleep?

No interference 0 1 2 3 4 5 6 Extreme interference

8. On the average, how severe has your pain been during the last week?

Not at all severe 0 1 2 3 4 5 6 Extremely Severe

9. How able are you to predict when your pain will start, get better, or get worse?

Not at all able to predict 0 1 2 3 4 5 6 Very able to Predict

Please continue on next page

10. How much has your pain changed your ability to take part in recreational and other social activities?

No change	0	1	2	3	4	5	6	Extreme change

11. How much do you limit your activities in order to keep your pain from getting worse?

Not at all	0	1	2	3	4	5	6	Very much

12. How much has your pain changed the amount of satisfaction or enjoyment you get from family related activities?

No change	0	1	2	3	4	5	6	Extreme change

13. How worried is your spouse (significant other) about you because of your pain?

Not at all worried	0	1	2	3	4	5	6	Extremely Worried

14. During the <u>past week</u> how much control do you feel you have had over your life?

No control	0	1	2	3	4	5	6	Extreme control

15. On an average day, how much does your pain vary (increase or decrease)?

Remains the same	0	1	2	3	4	5	6	Changes a lot

16. How much suffering do you experience because of your pain?

No suffering	0	1	2	3	4	5	6	Extreme suffering

17. How often are you able to do something that helps to reduce your pain?

Never	0	1	2	3	4	5	6	Very often

18. How much has your pain changed your relationship with your spouse, family, or significant other?

No change	0	1	2	3	4	5	6	Extreme change

19. How much has your pain changed the amount of satisfaction or enjoyment you get from work? (_____ Check here if you are not presently working.)

No change	0	1	2	3	4	5	6	Extreme change

20. How attentive is your spouse (significant other) to you because of your pain?

Not at all attentive	0	1	2	3	4	5	6	Extremely Attentive

21. During the <u>past week</u>, how well do you feel you've been able to deal with your problems?

Not at all	0	1	2	3	4	5	6	Extremely well

22. How much control do you feel you have over your pain?

No control at all	0	1	2	3	4	5	6	A great deal of control

23. How much has your pain changed your ability to do household chores?

No change	0	1	2	3	4	5	6	Extreme change

24. During the <u>past week</u>, how successful were you in coping with stressful situations in your life?

Not at all successful	0	1	2	3	4	5	6	Extremely successful

25. How much has your pain interfered with your ability to plan activities?

No interference	0	1	2	3	4	5	6	Extreme interference

Please continue on next page

26. During the <u>past week</u> how irritable have you been?

Not at all irritable 0 1 2 3 4 5 6 Extremely irritable

27. How much has your pain changed your friendships with people other than your family?

No change 0 1 2 3 4 5 6 Extreme change

28. During the <u>past week</u> how tense or anxious have you been?

Not at all tense or anxious 0 1 2 3 4 5 6 Extremely tense & anxious

<u>SECTION 2</u>: In this section, we are interested in knowing how your spouse (or significant other) responds to you when he or she knows you are in pain. On the scale listed below each question, **circle a number** to indicate how often your significant other responds to you in that particular way when you are in pain.

	Never						*Very often*
1. Ignores me ……	0	1	2	3	4	5	6
2. Asks me what he or she can do to help ……	0	1	2	3	4	5	6
3. Reads to me ……	0	1	2	3	4	5	6
4. Gets irritated with me ……	0	1	2	3	4	5	6
5. Takes over my jobs or duties ……	0	1	2	3	4	5	6
6. Talks to me about something else to take my mind off the pain ……	0	1	2	3	4	5	6
7. Gets frustrated with me ……	0	1	2	3	4	5	6
8. Tries to get me to rest ……	0	1	2	3	4	5	6
9. Tries to involve me in some activity ……	0	1	2	3	4	5	6
10. Gets angry with me……	0	1	2	3	4	5	6
11. Gets me pain medication ……	0	1	2	3	4	5	6
12. Encourages me to work on a hobby ……	0	1	2	3	4	5	6
13. Gets me something to eat or drink ……	0	1	2	3	4	5	6
14. Turns on the T.V. to take my mind off my pain ……	0	1	2	3	4	5	6

<u>SECTION 3</u>: Listed below are 19 daily activities. Please indicate <u>how often</u> you do each of these activities by circling a number on the scale listed below each activity. Please complete all 19 questions.

	Never						*Very often*
1. Wash dishes ……	0	1	2	3	4	5	6
2. Mow the lawn. (____ Check here if you do not have a lawn to mow.)	0	1	2	3	4	5	6
3. Go out to eat ……	0	1	2	3	4	5	6
4. Play cards or other games ……	0	1	2	3	4	5	6
5. Go grocery shopping ……	0	1	2	3	4	5	6
6. Work in the garden. (____ Check here if you do not have a garden.) ..	0	1	2	3	4	5	6
7. Go to a movie ……	0	1	2	3	4	5	6
8. Visit friends ……	0	1	2	3	4	5	6
9. Help with the house cleaning ……	0	1	2	3	4	5	6
10. Work on the car. (____ Check here if you do not have a car.) ……	0	1	2	3	4	5	6
11. Take a ride in a car or bus ……	0	1	2	3	4	5	6
12. Visit relatives. (____ Check here if no relatives within 100 miles.) …	0	1	2	3	4	5	6
13. Prepare a meal ……	0	1	2	3	4	5	6
14. Wash the car. (____ Check here if you do not have a car.) ……	0	1	2	3	4	5	6
15. Take a trip ……	0	1	2	3	4	5	6
16. Go to a park or beach ……	0	1	2	3	4	5	6
17. Do the laundry ……	0	1	2	3	4	5	6
18. Work on a needed household repair ……	0	1	2	3	4	5	6
19. Engage in sexual activities ……	0	1	2	3	4	5	6

<u>Please list any additional information or comments about your pain problem</u>

Please continue on next page

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers. *Please include any additional information you wish about the below answers. Thank you.*

		Never	Seldom	Sometimes	Often	Very Often
		0	1	2	3	4
1	How often do you have mood swings?					
2	How often have you felt a need for higher doses of medication to treat your pain?					
3	How often have you felt impatient with your doctors?					
4	How often have you felt that things are just too overwhelming that you can't handle them?					
5	How often is there tension in the home?					
6	How often have you counted pain pills to see how many are remaining?					
7	How often have you been concerned that people will judge you for taking pain medication?					
8	How often do you feel bored?					
9	How often have you taken more pain medication than you were supposed to?					
10	How often have you worried about being left alone?					
11	How often have you felt a craving for medication?					
12	How often have others expressed concern over your use of medication?					
13	How often have any of your close friends had a problem with alcohol or drugs?					
14	How often have others told you that you had a bad temper?					
15	How often have you felt consumed by the need to get pain medication?					
16	How often have you run out of pain medication early?					
17	How often have others kept you from getting what you deserve?					
18	How often, in your lifetime, have you had legal problems or been arrested?					
19	How often have you attended an AA or NA meeting?					
20	How often have you been in an argument that was so out of control that someone got hurt?					
21	How often have you been sexually abused?					
22	How often have others suggested that you have a drug or alcohol problem?					
23	How often have you had to borrow pain medications from your family or friends?					
24	How often have you been treated for an alcohol or drug problem?					

BDI®-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today.** Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
- 0 I do not feel sad.
- 1 I feel sad much of the time.
- 2 I am sad all the time.
- 3 I am so sad or unhappy that I can't stand it.

2. Pessimism
- 0 I am not discouraged about my future.
- 1 I feel more discouraged about my future than I used to be.
- 2 I do not expect things to work out for me.
- 3 I feel my future is hopeless and will only get worse.

3. Past Failure
- 0 I do not feel like a failure.
- 1 I have failed more than I should have.
- 2 As I look back, I see a lot of failures.
- 3 I feel I am a total failure as a person.

4. Loss of Pleasure
- 0 I get as much pleasure as I ever did from the things I enjoy.
- 1 I don't enjoy things as much as I used to.
- 2 I get very little pleasure from the things I used to enjoy.
- 3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
- 0 I don't feel particularly guilty.
- 1 I feel guilty over many things I have done or should have done.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6. Punishment Feelings
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7. Self-Dislike
- 0 I feel the same about myself as ever.
- 1 I have lost confidence in myself.
- 2 I am disappointed in myself.
- 3 I dislike myself.

8. Self-Criticalness
- 0 I don't criticize or blame myself more than usual.
- 1 I am more critical of myself than I used to be.
- 2 I criticize myself for all of my faults.
- 3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10. Crying
- 0 I don't cry any more than I used to.
- 1 I cry more than I used to.
- 2 I cry over every little thing.
- 3 I feel like crying, but I can't.

_____ Subtotal Page 1

Continued on Back

PEARSON

PsychCorp

11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.
2b I sleep a lot less than usual.

3a I sleep most of the day.
3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.
2b My appetite is much greater than usual.

3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

_____ Subtotal Page 2

_____ Subtotal Page 1

_____ Total Score

BAI®

NAME _____ **DATE** _____

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

	NOT AT ALL	MILDLY It did not bother me much.	MODERATELY It was very unpleasant, but I could stand it.	SEVERELY I could barely stand it.
1. Numbness or tingling.				
2. Feeling hot.				
3. Wobbliness in legs.				
4. Unable to relax.				
5. Fear of the worst happening.				
6. Dizzy or lightheaded.				
7. Heart pounding or racing.				
8. Unsteady.				
9. Terrified.				
10. Nervous.				
11. Feelings of choking.				
12. Hands trembling.				
13. Shaky.				
14. Fear of losing control.				
15. Difficulty breathing.				
16. Fear of dying.				
17. Scared.				
18. Indigestion or discomfort in abdomen.				
19. Faint.				
20. Face flushed.				
21. Sweating (not due to heat).				

CATAS (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.

We are interested in the types of thoughts and feeling 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 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 out 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

STAXI - Trait

Name: _____ Date: _____

Directions: Statements that people have used to describe themselves are given below. Read each statement and circle the appropriate number which corresponds to how you generally feel. There is no right or wrong answers. Do not spend too much time on any one statement, but give the answer that seems to describe how you generally feel. Use the key directly below for matching how you generally feel top the appropriate number.

Almost Never	Sometimes	Often	Almost Always
1	2	3	4

1. I am quick tempered	1	2	3	4
2. I have a fiery temper	1	2	3	4
3. I am a hot-headed person	1	2	3	4
4. I get angry when I'm slowed down by other's mistakes	1	2	3	4
5. I feel annoyed when I'm not given recognition for doing good work	1	2	3	4
6. I fly off the handle	1	2	3	4
7. When I get mad, I say nasty things	1	2	3	4
8. It makes me furious when I'm criticized in front of others	1	2	3	4
9. When I get frustrated, I feel like hitting someone	1	2	3	4
10. I feel infuriated when I do a good job and get a poor evaluation	1	2	3	4

SELF-EVALUATION QUESTIONNAIRE STAI Form Y-2

Name _____ Date_____

DIRECTIONS
A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you *generally* feel.

4 = Almost Always
3 = Often
2 = Sometimes
1 = Almost Never

1. I feel pleasant **1 2 3 4**
2. I feel nervous and restless.....**1 2 3 4**
3. I feel satisfied with myself.....**1 2 3 4**
4. I wish I could be as happy as others seem to be **1 2 3 4**
5. I feel like a failure..... **1 2 3 4**
6. I feel rested..... **1 2 3 4**
7. I am "calm, cool, and collected".....**1 2 3 4**
8. I feel that difficulties are piling up so that I cannot overcome them..... **1 2 3 4**
9. I worry too much over something that really doesn't matter.....**1 2 3 4**
10. I am happy.....**1 2 3 4**
11. I have disturbing thoughts..... **1 2 3 4**
12. I lack self-confidence..... **1 2 3 4**
13. I feel secure..... **1 2 3 4**
14. I make decisions easily **1 2 3 4**
15. I feel inadequate..... **1 2 3 4**
16. I am content..... **1 2 3 4**
17. Some unimportant thought runs through my mind and bothers me.....**1 2 3 4**
18. I take disappointments so keenly that I can't put them out of my mind **1 2 3 4**
19. I am a steady person..... **1 2 3 4**
20. I get in a state of tension or turmoil as I think over my recent concerns and interest ……..… **1 2 3 4**

Coping Strategies Questionnaire

Below is a list of things that people have reported doing when they feel pain. For each activity, please indicate, using the scale below, how much you engage in that activity when you feel pain. ***Please write the numbers you choose in the blanks beside the activities*.**

0	**1**	**2**	**3**	**4**	**5**	**6**
Never do that			Sometimes do that			Always do that

When I feel pain ...

_____1. I try to feel distant from the pain, almost as if the pain was in somebody else's body

_____2. I leave the house and do something, such as going to the movies or shopping.

_____3. I try to think of something pleasant.

_____4. I don't think of it as pain but rather as a dull or warm feeling.

_____5. It is terrible and I feel it's never going to get any better.

_____6. I tell myself to be brave and carry on despite the pain.

_____7. I read.

_____8. I tell myself that I can overcome the pain.

_____9. Take my medication.

_____10. I count numbers in my head or run a song through my mind.

_____11. I just think of it as some other sensation, such as numbness.

_____12. It is awful and I feel that it overwhelms me.

_____13. I play mental games with myself to keep my mind off the pain.

_____14. I feel my life isn't worth living.

_____15. I know someday someone will be there to help me and it will go away for awhile.

_____16. I walk a lot.

_____17. I pray to God it won’t last long.

_____18. I try not to think of it as my body, but rather as something separate from me.

_____19. I relax.

_____20. I don't think about the pain.

_____21. I try to think years ahead, what everything will be like after I’ve gotten rid of the pain.

_____22. I tell myself it doesn't hurt.

_____23. I tell myself I can't let the pain stand in the way of what I have to do.

_____24. I don't pay any attention to the pain.

_____25. I have faith in doctors that someday there will be a cure for my pain

_____26. No matter how bad it gets, I know I can handle it.

_____27. I pretend it's not there.

_____28. I worry all the time about whether it will end.

_____29. I lie down.

_____30. I replay in my mind pleasant experiences in the past.

_____31. I think of people I enjoy doing things with.

_____32. I pray for the pain to stop.

_____33. I take a shower or bath.

_____34. I imagine that the pain is outside of my body.

_____35. I just go on as if nothing happened.

_____36. I see it as a challenge and don't let it bother me.

_____37. Although it hurts, I just keep on going.

_____38. I feel I can't stand it anymore.

_____39. I try to be around other people.

_____40. I ignore it.

_____41. I rely on my faith in God.

_____42. I feel like I can't go on.

_____43. I think of things I enjoy doing.

_____44. I do anything to get my mind off the pain.

_____45. I do something I enjoy, such as watching TV or listening to music.

_____46. I pretend it's not a part of me.

_____47. I do something active, like household chores or projects.

_____48. I use a heating pad.

Based on all the things you do to cope, or deal with your pain, on an average day, how much control do you feel you have over it? Please circle the appropriate number below.

0	**1**	**2**	**3**	**4**	**5**	**6**
No control			Some control			Complete control

Based on all the things you do to cope, or deal with your pain, on an average day, how much are you able to decrease it? Please circle the appropriate number below.

0	**1**	**2**	**3**	**4**	**5**	**6**
Can’t decrease it at all			Can decrease it somewhat			Can decrease it completely