Instrument Title: The Psychosocial Pain Assessment Form (PPAF).
Instrument Author: Otis-Green, S., & The City of Hope Pain/Palliative Resource Center
INSTRUCTIONS FOR USE

This tool was designed to standardize a comprehensive psychosocial pain assessment for an interdisciplinary pain service. Through the use of a guided interview process, the clinician explores the impact of unrelieved pain on the patient/family experience in the following five domains: Economic, Social Support, Activities of Daily Living, Emotional Impact, and Coping Style.

Page 1 is designed to provide a synopsis of the patient/family situation for clinical reference and for presentation at an interdisciplinary pain meeting. It includes the interviewer’s impressions, interventions and recommendations as well as a summary of the key domains and associated level of concern.

Pages 2-7 contain questions regarding the five domains listed above. Following the questions in each domain is the opportunity for the patient and family (significant other) to rate their individual level of concern via a 0-10 rating scale (0 = no concern; 10 = greatest concern). Based upon his/her interpretation of the interview, the interviewer rates his/her subjective impressions of the patient’s level of concern. If a family member or significant other is present, his/her rating is then asked and finally the patient’s rating is obtained. Coherence and discrepancies in ratings between the interviewer, patient and family are noted and may then be explored for clinical significance.

Additionally, the assessment of prior history (including traumas such as physical and sexual abuse or unresolved losses) helps a clinician to focus interventions that respect past difficulties as well as past strengths and coping skills that may be transferable to the current pain experience.

This assessment tool is available in English and in two Spanish versions (children/adolescents and adults). Contact Shirley Otis-Green, MSW, LCSW (sotis-green@coh.org) with any questions regarding usage.
PSYCHOSOCIAL PAIN ASSESSMENT FORM

Psychosocial Pain Assessment Form

Patient: ___________________________ Age: ____ Date: __________________________
Med. Record #: __________________Significant Other: ____________________________
Diagnosis: _____________________________ Primary Physician: _____________________________
Pain Syndrome: ______________________________________________________________________
Duration of Pain: ___________________________ Assessed by: _______________________________

Please circle appropriate descriptors.
1. Build: Cachectic Thin Medium Heavy Obese
2. Attire: Disheveled Hospitalized Casual Professional
3. Eye Contact: Avoided Appropriate Stared
4. Attention: Distracted <-----------------------------|-----------------------> Hypervigilant
                  Focused
5. Manner: Flat Depressed Distant Cooperation
           Engaging Humorous Dramatic Agitated
           Anxious Tearful Sobbing Defensive
           Sarcastic Argumentative Angry Hostile
6. Verbal Expression: Terse Vague Average Articulate
                      Verbose
7. Reasoning Ability: Impaired Age-Appropriate Advanced
8. Overall Perspective: Pessimistic <-----------------------------|---------------------->
                      Optimistic
                      Unrealistic <-----------------------------|---------------------->
                      Realistic

9. Impressions: ______________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

10. Interventions: _____________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

11. Recommendations: __________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Rating (0-10) (0 = no concern, 10 = greatest concern)

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Introduction
We recognize that people are often concerned about the impact of pain on many areas of their lives. Unrelieved pain can cause economic, emotional, spiritual and social problems in addition to medical and physical ones. We will be looking at the overall impact of pain in your life and asking several questions to help the Pain Team better understand your personal concerns. The first area we will be addressing is the economic impact of your pain.

Economic
1. How are you supporting yourself financially?
   Work____________________ Family____________________ Disability____________________
   Partner___________________ Retirement/Pensions_________ Other______________________
   Friends___________________ Savings_____________________
2. Some people we see are concerned about meeting their economic needs. Which of these are worrisome to you?
   None ______
   Housing_________________ Clothing____________________ Prescriptions__________________
   Food____________________ Childcare__________________ Insurance_____________________
   Transportation___________ Medical bills________________ Other______________________
3. How has your economic situation changed? Better________________ Worse________________
   Describe:
   ______________________________________________________________________________
   ______________________________________________________________________________
   ______________________________________________________________________________
4. How upsetting have these changes been to you?
   Describe:
   ______________________________________________________________________________
   ______________________________________________________________________________
   ______________________________________________________________________________
5. What would be different in your life if you could afford to change it?
   Describe:
   ______________________________________________________________________________
   ______________________________________________________________________________
   ______________________________________________________________________________
6. Please rate your overall level of concern regarding these economic issues.
   Rating (0-10) (0 = no concern, 10 = greatest concern)
   Interviewer Patient Significant Other
   Economic __________ __________ _______________
Social Support
We believe that pain affects not just you, but your entire family. We'd like to look at ways in which you've noticed this impact.

1. Who do you turn to when you're uncomfortable or in pain?
   
   **Self** _______________ **Others** _______________ **God** _______________

   Name: _______________________________  Relationship: _______________________________

   How accessible is this person to you? ___________________________________________________
   How helpful is this to you? ___________________________________________________________

2. How comfortable are you sharing your feelings/fears with your loved ones?
   What makes this difficult for you?
   
   **Describe:**
   __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________

3. How satisfied are you with communication with your doctor/medical team?
   **Describe:**
   __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________

4. Losing people who are important to us affects us deeply. Have you suffered any recent losses?
   **Yes** ___ **No** ___
   
   **Describe:**
   __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________

   **Breaking up** ___________  **Separation** ___________  **Divorce** ___________
   **Death** ___________  **Moving away** ___________  **Other** ___________

5. Please rate your overall level of concern regarding these social support issues.

   **Rating (0-10)** (0 = no concern, 10 = greatest concern)

   **Social Support**
   **Interviewer** ___________  **Patient** ___________  **Significant Other** ___________
Activities of Daily Living

Physical Impact

Often unrelieved pain affects a person's daily routine. How has your pain impacted you in these activities of daily living?

1. Affecting your sleeping patterns? **Yes** ____ **No** ____
   - Frequent napping _____
   - Nightmares _____
   - Drowsiness _____
   - Chronic Fatigue _____
   - Difficulty going to sleep _____
   - Difficulty staying asleep _____
   - Difficulty waking up _____
   - Other _____

2. Affecting your eating habits? **Yes** ____ **No** ____
   - Weight loss/gain _____
   - Loss of appetite _____
   - Nausea/vomiting _____
   - Changes in taste _____
   - Special Diet _____
   - Feeding Tube _____
   - Difficulty swallowing _____
   - Other _____

3. Affecting your hygiene/elimination habits? **Yes** ____ **No** ____
   - Diarrhea _____
   - Catheter _____
   - Difficulty Grooming _____
   - Difficulty Bathing _____
   - Constipation _____
   - Ostomy _____
   - Incontinence _____
   - Other _____

4. Affecting your ability to move? **Yes** ____ **No** ____
   - Generalized weakness _____
   - Bed bound _____
   - Crutches/walker/cane _____
   - Getting in/out of car _____
   - Lifting/carrying _____
   - Limited range of motion _____
   - Wheel chair _____
   - Walking/standing _____
   - Climbing stairs _____
   - Other _____
   - No longer athletic _____
   - S.O.B. _____

5. Affecting your roles in your family? **Yes** ____ **No** ____
   - In what ways?
   - __________________________________________________________________________________

6. Affecting your sexual functioning? **Yes** ____ **No** ____
   - In what ways?
   - __________________________________________________________________________________

7. Affecting your physical appearance? **Yes** ____ **No** ____
   - In what ways?
   - __________________________________________________________________________________

8. How has your energy level changed? **Less** ____ **Same** ____ **Improved** ____

9. Please rate your overall level of concern regarding these physical changes.
   
   **Rating (0-10)** (0 = no concern, 10 = greatest concern)

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Emotional Pain affects our emotions. These questions will help us better understand your pain's impact upon you emotionally.

1. Have you been troubled by feelings of:
   - Depression Yes ___ No ___ Describe: ________________________________
   - Frustration/Anger Yes ___ No ___ Describe: __________________________
   - Anxiety Yes ___ No ___ Describe: __________________________________
   - Panic Attacks Yes ___ No ___ Describe: _____________________________
   - Mood Swings Yes ___ No ___ Describe: _____________________________
   - Difficulty Concentrating Yes ___ No ___ Describe: __________________
   - Loss of Motivation Yes ___ No ___ Describe: ________________________

2. Do you ever see or hear things that others don't? Yes ___ No ___
   Describe: _________________________________________________________
   __________________________________________________________________
   __________________________________________________________________

3. Are there any medical tests or procedures that frighten you? Yes ___ No ___
   Describe: _________________________________________________________
   __________________________________________________________________
   __________________________________________________________________

4. Have you ever thought about hurting yourself or taking your life? Yes ___ No ___
   Describe: _________________________________________________________
   __________________________________________________________________
   __________________________________________________________________

5. Please rate your overall level of concern regarding these emotional issues.
   Rating (0-10) (0 = no concern, 10 = greatest concern)
   Emotional issues Interviewer Patient Significant Other
   __________ _________ ______________
Coping

People handle pain and distress in many ways. These questions will help us to better understand how you cope with upsetting situations.

1. Sometimes, doing things we enjoy distracts us from our pain. What activities are you able to do that you enjoy?
   
   None _____
   Family _____  Friends _____  Hobbies _____  Reading _____
   Religion _____  Gardening _____  Traveling _____  Exercise _____
   Art/Music _____  TV _____  Pets _____  Other: _______

2. Some people find comfort in spirituality to help them cope with difficult situations. What role does spirituality have in helping you?
   Describe:

3. Many people in your situation ask "Why did this happen to me?" How have you attempted to "make sense" of your painful experiences?
   Describe:

4. Past stressful events can impact us in the present. What kinds of stress have you had to handle before? Describe:
   Child abuse? Yes ___ No ___ Describe:
   Sexual abuse? Yes ___ No ___ Describe:
   Family violence? Yes ___ No ___ Describe:

5. Some people find that counseling sessions or attending support groups can help them cope with stressful situations.
   Have you ever been in counseling? Yes ___ No ___ What was the focus of your therapy?
   Have you ever attended a support group? Yes ___ No ___ What kind?
   How helpful was this?

6. Some people are prescribed medications to help them cope. Which of these have you been prescribed?
   None _____
   Other:
   Anti-Anxiety medications? Yes ___ No ___ Describe:
   Anti-Depressant medications? Yes ___ No ___ Describe:
   Pain Medications? Yes ___ No ___ Describe:
   Do you ever take your prescriptions differently than ordered? Yes ___ No ___
   Describe:
7. Some people use other chemicals to help them cope. Which of these do you use?
   Tobacco? Yes ___ No ___ Describe: ____________________________________________
   Alcohol? Yes ____ No ____ Describe: __________________________________________
   Recreational Drugs? Yes ____ No ____ Describe: _________________________________
   Have you ever tried to stop using these? Yes ____ No ____ Describe: _________________________
   Do you worry about your usage of these? Yes ____ No ____ Describe: ________________________
   Has your family worried about your usage of these? Yes ____ No ____ Describe: ______________________

8. What changes do you expect in your future?
   Describe: __________________________________________________________________________

9. Overall, how satisfied are you with your present quality of life?
   Describe: __________________________________________________________________________

10. Please rate your overall level of concern regarding your ability to cope or manage your pain.
    Rating (0-10) (0= no concern, 10 = greatest concern)
    Interviewer _________ Patient _________ Significant Other _________
    Coping

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City of Hope National Medical Center

Publications
Otis-Green, S. (2006). Psychosocial Pain Assessment Form. In Dow (Ed.), Nursing Care of


The Psychosocial Pain Assessment Form can be found on the
City of Hope Pain/Palliative Resource Center website at
http://www.cityofhope.org/prc/pain_assessment.asp (English)
http://www.cityofhope.org/prc/pdf/Forma%20%20Adultos%20PS.pdf (Spanish - Adults)
http://www.cityofhope.org/prc/pdf/Formulario%20Ninos.pdf (Spanish - Children/Adolescents)