Pain Outcomes Questionnaire – VA: Time 2 (Discharge)

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Patient: _____ Social Security #:_____

1.) Enter today's date: ____ / ____ / ____ (MM/DD/YY)

2.) On a scale of 0 to 10, with 0 being no pain at all and 10 being the worst possible pain, how would you rate your pain on the **AVERAGE** during the **LAST WEEK**?

0 1 2 3 4 5 6 7 8 9 10
no pain at all — worst possible pain

3.) Does your pain interfere with your ability to walk?

0 1 2 3 4 5 6 7 8 9 10
not at all — all the time

4.) Does your pain interfere with your ability to carry/handle everyday objects such as a bag of groceries or books?

0 1 2 3 4 5 6 7 8 9 10
not at all — all the time

5.) Does your pain interfere with your ability to climb stairs?

0 1 2 3 4 5 6 7 8 9 10
not at all — all the time

6.) Does your pain require you to use a cane, walker, wheelchair or other devices?

0 1 2 3 4 5 6 7 8 9 10
not at all — all the time

7.) Does your pain interfere with your ability to bathe yourself?

0 1 2 3 4 5 6 7 8 9 10
not at all — all the time

8.) Does your pain interfere with your ability to dress yourself?

0 1 2 3 4 5 6 7 8 9 10
not at all — all the time

9.) Does your pain interfere with your ability to use the bathroom?

0	1	2	3	4	5	6	7	8	9	10
not at all										all the time

10.) Does your pain interfere with your ability to manage your personal grooming (for example, combing your hair, brushing your teeth, etc.)?

0	1	2	3	4	5	6	7	8	9	10
not at all										all the time

11.) Does your pain affect your self-esteem or self-worth?

0	1	2	3	4	5	6	7	8	9	10
not at all										all the time

12.) How would you rate your physical activity?

0	1	2	3	4	5	6	7	8	9	10
significant limitation in basic activities										can perform vigorous activities without limitation

13.) How would you rate your overall energy?

0	1	2	3	4	5	6	7	8	9	10
totally worn out										most energy ever

14.) How would you rate your strength and endurance **TODAY**?

0	1	2	3	4	5	6	7	8	9	10
very poor strength and endurance										very high strength and endurance

15.) How would you rate your feelings of depression **TODAY**?

0	1	2	3	4	5	6	7	8	9	10
not depressed at all										extremely depressed

16.) How would you rate your feelings of anxiety **TODAY**?

0 1 2 3 4 5 6 7 8 9 10
not anxious at all — extremely anxious

17.) How much do you worry about re-injuring yourself if you are more active?

0 1 2 3 4 5 6 7 8 9 10
not at all — all the time

18.) How safe do you think it is for you to exercise?

0 1 2 3 4 5 6 7 8 9 10
not safe at all — extremely safe

19.) Do you have problems concentrating on things **TODAY**?

0 1 2 3 4 5 6 7 8 9 10
not at all — all the time

20.) How often do you feel tense?

0 1 2 3 4 5 6 7 8 9 10
not at all — all the time

21.) How satisfied were you with the overall treatment you received?

0 1 2 3 4 5 6 7 8 9 10
no satisfaction — complete satisfaction

22.) How satisfied were you with staff warmth, respect, kindness, and willingness to listen?

0 1 2 3 4 5 6 7 8 9 10
no satisfaction — complete satisfaction

23.) How satisfied were you with the skills and competence of the staff?

0 1 2 3 4 5 6 7 8 9 10
no satisfaction — complete satisfaction

24.) How satisfied were you with the ease of getting appointments, hours of treatment, etc.?

0 1 2 3 4 5 6 7 8 9 10
no satisfaction — complete satisfaction

25.) Would you recommend this treatment to someone you know who has a pain problem?

0 1 2 3 4 5 6 7 8 9 10
not recommended — strongly recommended

26.) Are you currently taking any narcotic medications **ON A DAILY BASIS** (for example, codeine, Darvon, Demerol, Dilaudid, Duragesic, MS Contin, Percocet, Vicodin, Lortab, Oramorph, Tylenol #3 or #4, etc.)?

A) yes B) no

If you answered **YES** to question #26, **COMPLETE QUESTIONS #27 & #28 ONLY**.

If you answered **NO** to question #26, **STOP HERE**.

27.) How long have you been using narcotic medication **ON A DAILY BASIS** for your pain problem?

_____ Years _____ Months

28.) Please rate the degree of pain relief you currently receive from these medications:

0 1 2 3 4 5 6 7 8 9 10
no relief — complete relief