rise
BC WELLNESS CENTRE

203-518 Lake St.
Nelson, B.C. V1L 4C6
risebc.com

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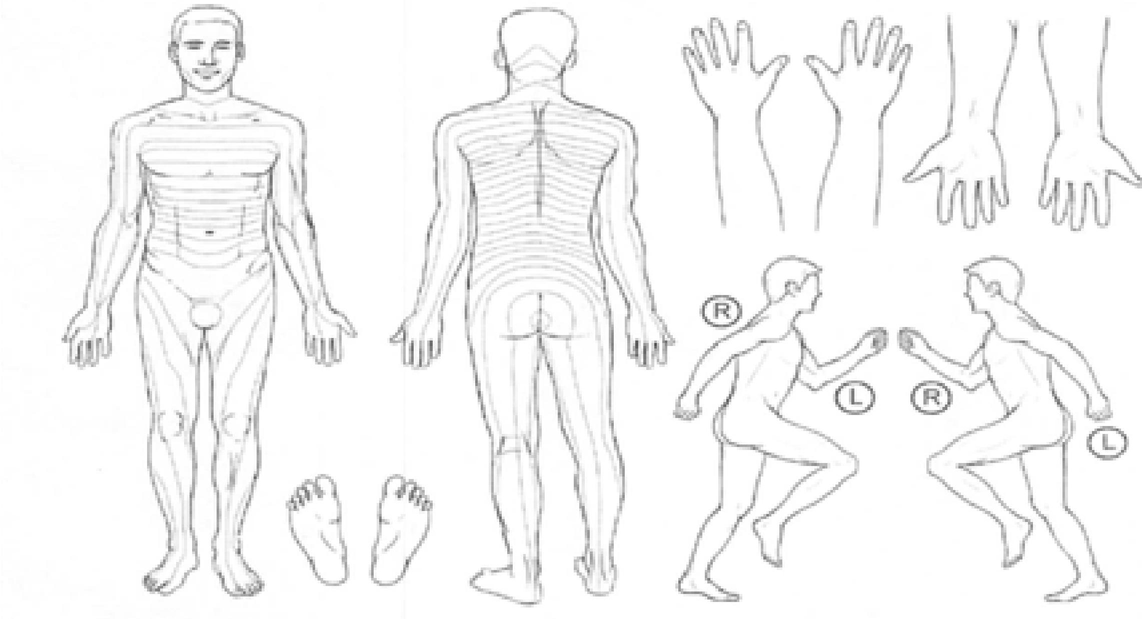
**The attached intake paperwork must be completed by the patient and submitted with the referral.**

## BRIEF PAIN INVENTORY

Date:

Name:

**On the diagram below, shade in the areas where you feel pain. Put an "X" on the areas where it hurts the most (print this document off and fill in).**




What things make your pain feel worse?

What things make your pain feel better?

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What treatment or medication are you receiving for you pain?

## PAIN FOLLOW UP QUESTIONNAIRE

Please rate your pain by checking the number that best describes your pain at its WORST in the past 24 hours.

| No Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Pain |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

Please rate your pain by checking the number that best describes your pain at its LEAST in the past 24 hours.

| No Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Pain |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

Please rate your pain by checking the number that best describes your pain on AVERAGE.

| No Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Pain |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

Please rate your pain by checking the number that best describes your pain RIGHT NOW.

| No Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Pain |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

In the last 24 Hours, how much relief have your pain treatment or medications provided? Please check the one percentage that shows most how much RELIEF you have received.

| No Relief | 0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% | Complete Relief |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

Check the one number that describes how, during the past 24 hours, pain has interfered with your:

A: General Activities

| Does Not Interfere | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely Interferes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

B: Mood

| Does Not Interfere | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely Interferes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

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C: Walking Ability

| Does Not Interfere | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely Interferes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

D: Normal Work (includes both work outside the home and housework)

| Does Not Interfere | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely Interferes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

E: Relations with other people

| Does Not Interfere | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely Interferes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

F: Sleep

| Does Not Interfere | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely Interferes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

G: Enjoyment of Life

| Does Not Interfere | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely Interferes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

This injury is related to a **current** WCB claim: Yes No

## SOAPP

| Please CHECK the answer the questions below using the following scale: | Never (0) | Seldom (1) | Sometimes (2) | Often (3) | Very Often (4) |
|---|---|---|---|---|---|
| 1. How often do you have mood swings? | | | | | |
| 2. How often do you smoke a cigarette within an hour after you wake up? | | | | | |
| 3. How often have you taken medication other than the way that it was prescribed? | | | | | |
| 4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? | | | | | |
| 5. How often, in your lifetime, have you had legal problems or been arrested? | | | | | |

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Please include any additional information you wish about the above answers.

## PCS Screen

Everyone experiences painful situations at some point in their lives. We are interested in the types of thoughts and feeling that you have when you are in pain. Please indicate (with a CHECK MARK) the degree to which you have the following thoughts and feelings when you are experiencing pain. Enter total where applicable.

| Please CHECK the answer the questions below using the following scale: | Not at All (0) | Slightly (1) | Moderately (2) | Greatly (3) | All the Time (4) |
|---|---|---|---|---|---|
| I become afraid that the pain will get worse | | | | | |
| I keep thinking of other painful events | | | | | |
| I wonder whether something serious may happen | | | | | |

M: /12

| | | | | | |
|---|---|---|---|---|---|
| I anxiously want the pain to go away | | | | | |
| I can't seem to keep it out of my mind | | | | | |
| I keep thinking about how much it hurts | | | | | |
| I keep thinking about how badly I want the pain to stop | | | | | |

R: /16

| | | | | | |
|---|---|---|---|---|---|
| I worry all the time about whether the pain will end | | | | | |
| I feel I can't go on | | | | | |
| It's terrible and I think it's never going to get any better | | | | | |
| It's awful and I feel that it overwhelms me | | | | | |
| I feel I can't stand it anymore | | | | | |
| There's nothing I can do to reduce the pain's intensity | | | | | |

H: /24