Welcome to the PEAK Program at The Pain Center

You have been referred to The Pain Center's PEAK Program for a comprehensive evaluation. We provide a multidisciplinary behavioral approach to chronic pain management designed to assess a patient's struggle with chronic pain syndromes. From the evaluation, recommendations will be provided and an outpatient treatment program will be designed for those patients identified to benefit from our approach and services.

The first step in the process is a complete evaluation with our professional staff of a psychologist and a physician. The first half of your evaluation will be spent completing several questionnaires designed to help us better understand your individual struggles with Fibromyalgia Syndrome. The second half of your evaluation will involve examinations by our psychologist, physician, and physical therapist. Following the evaluation, the team will determine what recommendations will be most helpful to you .

What is the PEAK Program all about?

THE TEAM: The treatment team consists of a physician, a nurse practitioner, a nurse, a psychologist, a physical therapist, an occupational therapist, a program coordinator, and two office staff.

GOAL: Improve function and quality of life through symptom management.

METHODS OF TREATMENT: The following activities are various treatment measures that many be recommended in order to assist you in becoming increasingly active. The treatment methods will vary depending on the results of the initial evaluation.

1. Exercise: A physical therapy program will be developed for each individual. Physical endurance will be evaluated and a program will then be established for increasing your endurance in these activities. A home program for stretching and exercise will be established.
2. Medication: Our physician and nurse practitioner will manage medications once you are in the treatment program. Effectiveness of medications will be reviewed and changes made as needed.
3. Psychosocial: Psychological services will include all or some of the following: reduce emotional distress, stress management, weight loss motivation, goal setting for rehabilitation, and education regarding symptom coping strategies.
4. Biofeedback & Relaxation Training: These interventions, provided by the psychologist, are employed for both direct pain control and stress management. These therapies are often coordinated with physical therapy and, when indicated, is part of a larger stress management protocol.
5. Education: Lectures with both Medical and Psychological staff members are used to assist you in learning more about chronic pain and its effect on your everyday life.

How do I Schedule Treatment?

In the interest of providing the best environment for treatment, we would like to provide you with some information about the scheduling process.

Approximately one week after completing your evaluation you will receive a letter summarizing the findings of the evaluation as well as the Team's recommendations for your treatment program. **Upon receiving your letter, we ask that you call us at (616) 233-3480 and let us know when you are available to attend appointments.**

As we meet the challenge of scheduling your appointments, there are a few things we'd like you to keep in mind:

- We ask that you provide us all the timeframes when you will be available for therapy appointments.
- Late afternoon hours are often limited. We request that your available times for therapy include morning or early afternoon appointments if you are currently missing in school or not working.
- A typical Program involves 7 – 10 hours of therapy per week.

Our program coordinator, Holly Polanic, will contact you once a place in the program becomes available and together, you will discuss a schedule that will best accommodate the recommended treatment program and your availability. We will be available to assist you with the scheduling process and problem solve at any point as needed.

A Note on Medication Management

Please note that management of your medication will <u>not</u> begin with the evaluation. Your medication management will continue with your current physician.

Dr. Hudson or Josh Brinks will only begin managing medication when treatment is started for the program. <u>You will be provided with no prescriptions at the time of evaluation.</u>

If you have questions, please contact our Program Coordinator, Holly Polanic, at (616) 233- 3480.

For additional information about The Pain Center and Mary Free Bed Hospital, please visit our website at:

www.MaryFreeBed.com/ThePainCenter

Mary Free Bed
Rehabilitation Hospital

1155 East Paris Ave. SE Suite 200
Grand Rapids, MI 49546
(616) 233-3480

NOTICE OF INFORMATION PRACTICES

Patient Name _____ MR#_____

I acknowledge that I have received a copy of the Mary Free Bed Hospital Notice of Information Practices. I understand that this notice outlines how Mary Free Bed Hospital may share my health information for treatment, payment, and healthcare operations.

My signature constitutes my acknowledgment that I have been provided with a copy of this notice and that I have had the opportunity to read it and ask questions.

_____ _____

Signature of Patient or Legal Representative **Date**

If an acknowledgment is not obtained from the patient or representative, document below the provider's good faith effort to obtain the acknowledgment and the reason why the acknowledgment was not obtained.

Reason acknowledgment not obtained:_____

_____

_____

_____

_____ _____

MFB Staff Member **Date**

Mary Free Bed
Rehabilitation Hospital
1155 East Paris Ave. SE Suite 200
Grand Rapids, MI 49546
(616) 233-3480

Outpatient Treatment Consent Form

I certify that the initials _____ are my own and that they will constitute my legal and binding signature for the purpose of this form.

_____

Date Name of Patient or Representative Relationship

Treatment Consent

I,_____(print patient name), have had the following consents and authorizations explained to me. My signature/initials indicate my approval for each item as an outpatient of Mary Free Bed Rehabilitation Hospital or Mary Free Bed Orthotics and Prosthetics (MFB).

Knowing that I have a condition requiring outpatient treatment, I voluntarily consent to such treatment, diagnostic or therapeutic procedures and hospital care by MFB as deemed necessary or advisable by
Dr._____, his/her assistants or designees. I am aware that the practice of medicine is not an exact science. I acknowledge that no guarantees have been made to me as to the results of this outpatient treatment. I have been informed that I may revoke my consent to treatment at any time, but that it is my responsibility to communicate such revocation to my doctor in a timely manner.

During my outpatient treatment, I consent to being attended by doctors, residents, nurses, laboratory and radiology technicians, allied health professionals and students. I understand that communication between these caregivers is important for coordination of care. I understand that MFB participates in teaching programs for a number of health care professionals and participates in approved medical research. I further consent to the observation of my diagnosis and treatment and the review of my records as part of training for these health care professionals.

I understand that MFB does not provide emergency services and may transfer me to an emergency room, without my consent, if I develop potentially life-threatening symptoms.

I am aware that, as a patient of this facility, MFB may test me for the presence of HBV, HBC or an HIV antibody, without my consent, if any health care worker or emergency service worker is exposed to my blood or other body fluids. I understand that Michigan law permits this test and that I will be informed if this occurs. I further understand that the same Michigan law provides that MFB may also test me for other blood-borne diseases at that time.

I understand that to be able to participate in therapy and to avoid complications, I may not use alcohol within hospital settings, during hospital sponsored, or supervised therapeutic activities. MFB does not allow the use of illegal substances, as they are detrimental to treatment. I further understand that if alcohol, drugs or apparatus are found while I am in the treatment setting, staff will confiscate and discard these items. I also understand that if I do not comply with this policy, MFB staff will meet with me to decide consequences. I understand that I may be discharged from outpatient treatment at MFB if I am unable to cooperate with my treatment plan.

I understand that Mary Free Bed has no responsibility for loss of clothing, money, valuables, dentures, glasses or any other of my personal items and I understand that I should make arrangements to safeguard items during my treatment times. Initials _____

FINANCIAL RECORDS AUTHORIZATION AND INSURANCE

ASSIGNMENT OF BENEFITS

In consideration for services and supplies to be rendered, I agree to pay MFB for these services and supplies according to its regular rates and charges at the time these services and supplies were rendered. This account is due upon discharge, or at MFB option, upon the expiration of each thirty (30) days of outpatient treatment. If this account is delinquent, I agree to pay all expenses including, but not limited to, court costs and actual attorney fees incurred by MFB in collecting this account. I also agree to assign to MFB any right or cause of action that I may have against any third person to collect and recover for the expense of this account.

I further authorize MFB to release any billing information for payment of account by any insurance company or employer. I authorize any insurance companies to pay directly to MFB liability and/or medical insurance proceeds for all services and supplies rendered by MFB for this admission. I understand that I am financially responsible to MFB for all services and supplies not covered by the liability and/or medical coverage insurance. Initials _____

MEDICAL RECORDS AUTHORIZATION

I authorize MFB to release the minimum necessary information contained in my patient record (including photographs, slides, videotapes, audio recordings or other digital images) to schools, other educational programs, and other health care providers for continuing care needs or to my insurance company or employer for payment of my account. I understand that this information may include mental health and social work records.

I further authorize MFB to release information contained in my patient record pertaining to alcohol and drug abuse, communicable diseases, HIV, AIDS and ARC.

I give consent for an insurance company representative to attend team conferences during admission at MFB. I understand that this consent is not mandatory but may be helpful in planning further medical care. I may revoke this authorization anytime, but not retroactive to release of information made in good faith. Initials _____

RELEASE FOR AUDIO-VISUAL MATERIAL

I understand that MFB staff may make photographs, slides, videotapes, audio recordings, or other digital images of me and I authorize MFB to use these materials as part of my treatment program and for internal educational purposes only. I understand that MFB will not use these materials for external reasons without my specific consent. I understand that my signature releases MFB from any financial or legal responsibility for this audio-visual material. Initials _____

AUTHORIZATION FOR DISCLOSURE FOR DURABLE MEDICAL EQUIPMENT

I authorize MFB to release the minimum necessary information from my outpatient treatment records to providers to simplify ordering my durable medical equipment. Specific information to be disclosed will be face sheet information, physician orders and selected information to process my durable medical equipment order. I understand I may revoke this authorization anytime, but not retroactive to release of information made in good faith. Unless revoked by me, this authorization will expire one year from today's date. Initials _____

AUTHORIZATION FOR DISCLOSURE OF INFORMATION FROM SCHOOLS

I authorize my school/my child's school to release records to MFB. This release covers academic information, therapy reports and psychological testing. I may revoke this authorization anytime, but not retroactive to release of information made in good faith. Initials _____

OFF-GROUND ACTIVITIES/TRANSPORTATION RELEASE

I understand that MFB may conduct off-grounds treatment activities and I authorize MFB to conduct this treatment according to my doctor's orders. I understand that certain hospital policies related to my care may be modified for practical reasons during off-grounds activities. I authorize MFB to provide me transportation for off-grounds activities. Initials _____

I have agreed to the items reviewed above unless specifically indicated. Initials _____

Witness Signature:_____ Date: _____

The Pain Center
1155 East Paris Ave SE, Suite 200
Grand Rapids, MI 49546
616-233-3480 / 616-233-3488
Fax: 616-233-3481

Restoring Hope and Freedom
Mary Free Bed
Rehabilitation Hospital

Cancellation / No Show Policy

We encourage you to keep all scheduled appointments to maximize the benefit of your evaluation. If you are unable to attend a scheduled evaluation appointment, **48 hours notice is required.**

If 48 hours notice is not given, you will be charged a

cancellation fee of $100.

This fee is NOT covered by your insurance company and payment is expected before we will reschedule your evaluation appointment. Payment can be in the form of cash, check, or credit card. Two consecutive appointment no-shows may result in a refusal to reschedule your appointments.

Please be advised that if you are **10 or more minutes late** for your evaluation, we will re-schedule your first appointment to a later date.

Signature:_____ Date:_____

Print Name:_____

Mary Free Bed
Rehabilitation Hospital
The Pain Center
1155 East Paris Ave SE, Suite 200
Grand Rapids, MI 49546
616-233-3480 / 616-233-3488
Fax: 616-233-3481

Authorization to Disclose Health Information

Patient Name: _____Date of Birth: _____
I authorize the use or disclosure of the above named patient's health information as described below. The following individual or organization is authorized to exchange information

Health information may be exchanged with and used by:

_____	_____
Name and Title	Name and Title
_____	_____
Address	Address
_____	_____
City State Zip	City State Zip
_____	_____
Phone Number Fax Number	Phone Number Fax Number

For the purpose of: ☐ Continued Care ☐ Legal ☐ Insurance/Billing
☐ Personal ☐ Eligibility (DDS, DSS, CSHCS)
☐ Other _____

Please release the following information:
☐ Entire Medical Record
☐ Other:_____

- I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.
- I understand that I have the right to revoke ths authorization at any time. If I revoke this authorization, I must do so in writing and present my written recovation to Health Information Management. The revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire one year from the date signed.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to receive treatment. I understand that I may inspect or obtain copies of the information to be used or disclosed. I understand that any disclosure of information by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Manager at 616-242-0355.

_____ _____
(Date) (Signature of Patient or Legal Representative) (Relationship)

_____ _____
(Date) (Signature of Witness)

The Pain Center
1155 East Paris Ave SE, Suite 200
Grand Rapids, MI 49546
616-233-3480 / 616-233-3488
Fax: 616-233-3481

Restoring Hope and Freedom
Mary Free Bed
Rehabilitation Hospital

Would you like to be added to our e-mail list?

Once per month, we will send a brief newsletter with pain management tips. We will never Release your e-mail to another agency. You can unsubscribe at any time.

YES: _____ NO: _____

E-Mail Address: _____

Print Name: _____

How did you hear about The Pain Center? (Check all that apply):

Internet

____ Web Search
(Circle engine: Bing Google Yahoo
Other: _____)

____ The Pain Center Web Page
(www.MaryFreeBed.com/ThePainCenter.aspx)

____ You Tube

____ The Pain Center e-newsletter

Other

____ Yellow Pages

____ Physician
(Name:_____)

____ Physical Therapist
(Name:_____)

____ Case Manager
(Name:_____)

____ Seen on Radio or TV

____ Friend/Family told me

____ Knew of Mary Free Bed, so I checked there

PEAK REHABILITATION PROGRAM
1155 East Paris Ave SE, Suite 200
Grand Rapids, Michigan 49546
Phone: (616) 233-3480

Please print or type information on this form. Please use black ink if possible. Check boxes where appropriate.

Name _____(_____) Date _____
Previous Name

Address _____
(Street) (City) (State) (Zip)

Telephone Home(_____) _____Work (_____)_____
Cell (_____)_____Please list only if OK for use to contact you and/or leave msg.

Social Security # _____

Date of Birth _____ Age _____ Single ___ Married ___ Separated ___ Divorced ___
Spouse's Name _____ DOB: _____

Emergency Contact: _____ Telephone #: _____

Pharmacy Name: _____ Location: _____ Telephone #: _____

Who is your present treating physician: _____

Group/Office Associated:_____

Who is your family physician: _____

Group/Office Associated :_____

1. a. Is your pain problem the result of an injury? Yes _____ No _____

b. If yes, date of injury _____ Location _____

Description _____

c. If no, when did your pain problem start? _____

Cause? _____

2. a. Have you had surgery for your pain problem?_____

b. Dates of surgeries (if any) _____

3. Where in your body do you experience pain? _____

4. **Please list all prescription and non-prescription medications you now take.**

Name	Amount	How Often

5. a. **How many days have you been in the hospital for pain problems in the past**
3 months? _____
12 months? _____

b. **How many times do you estimate you went to your doctor's office because of your pain problem during the last 3 months? _____**
12 months? _____

c. **How many times do you estimate you went to the emergency room for treatment of your pain problem in the last 3 months? _____**
12 months? _____

d. **How many times do you estimate that you received physical therapy treatment for your pain problem in the last 3 months? _____**
12 months? _____

6. **School: Circle the highest grade completed**

Grammar/High School 1 2 3 4 5 6 7 8 9 10 11 12

College 1 2 3 4 5 6

Trade/Business School _____

Other _____

7. **Employment:**

a. **Present or most recent employer:**

Name: _____ Supervisor: _____

Address:_____
Street City State Zip Phone

Job Title: _____ Wages: _____

b. **Dates Employed From: _____ To: _____**

c. **If currently working, how many days absent in the past month: _____**

d. **If you are off work, what is the last date that you worked: _____**

8. **a.** **Are you currently involved in any legal activity as a result of your pain?**
(For example: Lawsuit, compensation litigation) Yes _____ No _____
If yes, please describe: _____

_____

b. **Lawyer's name: _____**

_____(_____)_____
Street City State Zip Telephone

c. **Date of pending legal action: _____**

d. **Do you plan any future legal action? Yes _____ No _____**

If yes, please explain: _____

9. **Please indicate your current medical insurance coverage *for this evaluation*: Be sure to include <u>all</u> policy/claim numbers.**

a. **Private Health or HMO Insurance: _____**

Group #_____ Plan #_____ Contract # _____

Policy Holder _____ DOB _____

Social Security # _____

Policy Holder's Employer _____ Address _____

Employer Phone # _____

******* *Please list this same information on the back of this sheet if you have a Secondary or tertiary health insurance that would apply for this evaluation.****

b. **Medicaid: ID# _____** **c.** **Medicare: Policy #_____**

d. **Auto No Fault: Claim # _____**

Name of Insurance Company: _____

Address _____

Adjustor's Name _____ Telephone (___)_____

Policy Holder's Employer _____ Address _____

Date of Injury_____

e. **Worker's Compensation: Claim # _____**

Name of Insurance Company: _____

Address_____

Adjustor's Name _____ Telephone(___)_____

Name of Employer: _____ Telephone (___)_____

Employer Address: _____

Date of Injury_____

10. Are you currently working with a Rehabilitation Case Manager? Please specify:

_____

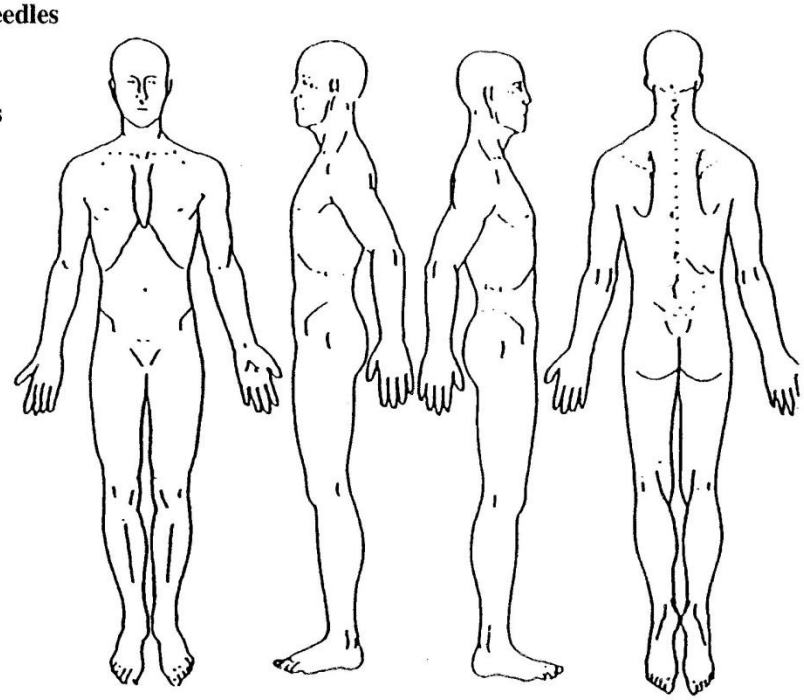
11. Have you applied for social security disability? Yes _____ No _____

a. Have you been awarded social security disability status? Yes ____ No ____ Date: _____

12.

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

Key: 0000 Pins & Needles
XXX Burning
////// Stabbing
= = Numbness
Aching



The Pain Center
1155 East Paris Ave SE, Suite 200
Grand Rapids, MI 49546
Phone: 616-233-3480
Fax: 616-233-3481

Restoring Hope and Freedom
Mary Free Bed
Rehabilitation Hospital

Please Return on: _____

Evaluation Instructions

The following questionnaires will help us get a complete understanding of your pain experience. They will ask about many things including pain levels and descriptions, your attitudes about treatment and pain, possible emotional reactions, and current levels of functioning. Some may not apply (since we are asking about many things) – and that's okay. All the questions have a response to match your experience.

The results will help us develop an individualized treatment plan for you. If you decide to come into treatment, we will be able to track your progress using these measures.

- There are no right or wrong answers
- Please answer all questions as you truly feel
- Choose only 1 answer, the one that is *most* accurate
  - Or how you feel *on average,* or *most of the time*
- Don't spend too much time on any 1 question
- Questions are printed on both sides. Please be careful not to miss the other side.

If you have any questions, please ask.
Thanks,
Dr. Hanson, Dr. O'Connor, Dr. Makuch, & Mr. Hillman

Name: _____ Date: _____ IE / DC / FU

Please rate your pain on a scale of 0 (no pain) to 100 (worst pain you could imagine):

1. Average pain over past month: _____
2. Worst pain over last month: _____
3. Least pain over last month: _____
4. Pain level right now: _____
5. Pain level that I could cope with and still work and live my life: _____

PDS

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, Recreational Activity: activities done alone or with others such as hobbies, puzzles, knitting, dining out, going to movies, social functions, (do not include watching T.V.).
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) Occupation 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, and others.
NO Disability 0 1 2 3 4 5 6 7 8 9 10 TOTAL Disability

© 1998, Kenneth R. Lofland, Ph.D., PDS

Copyright © 1995
Michael JL Sullivan

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 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.

0 – not at all	**1** – to a slight degree	**2** – to a moderate degree	**3** – to a great degree	**4** – all the time

When I'm in pain …

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

CES-D
Evaluation

Please circle the number for each statement which best describes how often you felt or behaved the way during the past week. Please do not leave any items blank.

Scale:
0 Rarely or none of the time (less than 1 day)
1 Some or a little of the time (1-2 days)
2 Occasionally or a moderate amount of time (3-4 days)
3 Most or all the time (5-7 days)

	<1 day	1-2 days	3-4 days	5-7 days
1. I was bothered by things that usually don't bother me……..	0	1	2	3
2. I did not feel like eating; my appetite was poor…….	0	1	2	3
3. I felt I could not shake off the blues even with help from my family or friends.....	0	1	2	3
4. I felt that I was just as good as other people..	0	1	2	3
5. I had trouble keeping my mind on what I was doing……..	0	1	2	3
6. I felt depressed…….	0	1	2	3
7. I felt that everything I did was an effort……	0	1	2	3
8. I felt hopeful about the future……..	0	1	2	3
9. I thought my life had been a failure…….	0	1	2	3
10. I felt fearful……..	0	1	2	3
11. My sleep was restless…….	0	1	2	3
12. I was happy…….	0	1	2	3
13. I talked less than usual……	0	1	2	3
14. I felt lonely…….	0	1	2	3
15. People were unfriendly……..	0	1	2	3
16. I enjoyed life……..	0	1	2	3
17. I had crying spells…….	0	1	2	3
18. I felt sad…….	0	1	2	3
19. I felt that people dislike me……...	0	1	2	3
20. I could not get "going"……..	0	1	2	3

CPAQ

DIRECTIONS: Below you will find a list of statements. Please rate the truth of each statement as it applies to you. Use the following rating scale to make your choices. For instance, if you believe a statement is "Always True", you would write a 6 in the blank next to the statement.

0	1	2	3	4	5	6
Never True	Very Rarely True	Seldom True	Sometimes True	Often True	Almost Always True	Always True

_____ 1. I am getting on with the business of living no matter what my level of pain is.

_____ 2. My life is going well, even though I have chronic pain.

_____ 3. It's OK to experience pain.

_____ 4. I would gladly sacrifice important things in my life to control this pain better.

_____ 5. It's not necessary for me to control my pain in order to handle my life well.

_____ 6. Although things have changed, I am living a normal life despite my chronic pain.

_____ 7. I need to concentrate on getting rid of my pain.

_____ 8. There are many activities I do when I feel pain.

_____ 9. I lead a full life even though I have chronic pain.

_____ 10. Controlling pain is less important than any other goals in my life.

_____ 11. My thoughts and feelings about pain must change before I can take important steps in my life.

_____ 12. Despite the pain, I am not sticking to a certain course in my life.

_____ 13. Keeping my pain level under control takes first priority whenever I'm doing something.

_____ 14. Before I can make any serious plans, I have to get some control over my pain.

_____ 15. When my pain increases, I can still take care of my responsibilities.

_____ 16. I will have better control over my life if I can control my negative thoughts about pain.

_____ 17. I avoid putting myself in situations where my pain might increase.

_____ 18. My worries and fears about what pain will do to me are true.

_____ 19. It's a relief to realize that I don't have to change my pain to get on with my life.

_____ 20. I have to struggle to do things when I have pain.

SURVEY OF PAIN ATTITUDES- SOPA

INSTRUCTIONS: Please indicate how much you agree with each of the following statements about your pain problem by using the following scale.

0	1	2	3	4
Very Untrue For me	Somewhat Untrue for me	Neither true nor untrue for me (or does not apply)	Somewhat true for me	Very true for me

1	The pain I feel is a sign that damage is being done	0	1	2	3	4
2	If my pain continues at its present level, I will be unable to work	0	1	2	3	4
3	The amount of pain I feel is out of my control	0	1	2	3	4
4	Pain does not have to mean that my body is being harmed	0	1	2	3	4
5	There is little that I can do to ease my pain	0	1	2	3	4
6	My pain problem does not need to interfere with my activity level.	0	1	2	3	4
7	Exercise and movement are good for my pain	0	1	2	3	4
8	If I exercise, I could make my pain problem much worse	0	1	2	3	4
9	I can control my pain by changing my thoughts	0	1	2	3	4
10	I consider myself to be disabled	0	1	2	3	4
11	I have learned to control my pain	0	1	2	3	4
12	My pain does not stop me from leading a physically active life.	0	1	2	3	4
13	I am not in control of my pain.	0	1	2	3	4
14	Exercise can decrease the amount of pain I experience	0	1	2	3	4
15	My pain would stop anyone from leading an active life	0	1	2	3	4

PASS

Individuals who experience pain develop different ways to respond to that pain. We would like to know what you do or what you think about when in pain. Please use the rating scale below to indicate how often you engage in each of the following thoughts or activities. Record your rating on the line next to each item.

Never					Always
0	**1**	**2**	**3**	**4**	**5**

_____1. I think that if my pain gets too severe, it will never decrease.

_____2. My mind is calm when I am in pain.

_____3. When I feel pain, I try to stay as still as possible.

_____4. I become sweaty when in pain.

_____5. When I feel pain, I am afraid that something terrible will happen.

_____6. My thoughts are agitated and keyed up as pain approaches.

_____7. I go immediately to bed when I feel severe pain.

_____8. Even though it hurts, I know that I'm going to be O.K.

_____9. My body gets shaky when I hurt.

_____10. I feel disoriented and confused when I hurt.

_____ 11. When pain gets severe, I call my doctor or go to the emergency room.

_____12. I begin trembling when engaged in an activity that increases pain.

_____ 13. When I feel pain, I become afraid of dying.

_____14. I can't think straight when in pain.

_____15. I will stop any activity as soon as I sense pain coming on.

_____16. Even if I do an activity that causes pain, I know it will decrease later.

_____17. Pain seems to cause my heart to pound or race.

_____18. I think I have a serious medical problem that my physician has failed to uncover.

_____19. As soon as pain comes on, I take medication to reduce it.

_____20. I have pressure or tightness in my chest when in pain.

_____21. When I feel pain I think that I might be seriously ill.

_____22. During painful episodes it is difficult for me to think of anything besides the pain.

_____23. I avoid important activities when I hurt.

_____24. When I sense pain, I feel dizzy or faint.

_____25. Pain sensations are terrifying.

_____26. When I hurt, I think about the pain constantly.

Never					Always
0	**1**	**2**	**3**	**4**	**5**

_____27. I take medication if I know I need to do something that usually increases pain.

_____28. I have trouble catching my breath when I have pain sensations.

_____29. I dread feeling pain.

_____30. I am bothered by unwanted thoughts when I'm in pain.

_____31. If a chance comes to do something I enjoy, I do it even if it causes pain.

_____32. Pain makes me nauseous.

_____33. When pain comes on strong, I think that I might become paralyzed or more disabled.

_____34. I find it hard to concentrate when I hurt.

_____35. I seek reassurance that I am O.K. during times of more severe pain.

_____36. I find it difficult to calm my body down after periods of pain.

_____37. I worry when I am in pain.

_____ 38. My stomach bothers me when I experience pain.

_____39. I try to avoid activities that cause pain.

_____40. I can think pretty clearly even while experiencing severe pain.

SIP

HM

This group of statements have to do with any work you usually do in caring for your home or yard. Considering just those things that you do, please check **only** those statements that you are **sure** describe you today and are related to your pain or injury.

1. Do work around the house only for short periods of time or rest often. _____
2. Am doing less of the regular daily work around the house than I would usually do _____
3. Am not doing any of the regular daily work around the house that I usually do. _____
4. Am not doing any of the maintenance or repair work that I would usually do in my home or yard _____
5. Am not doing any of the shopping that I would usually do. _____
6. Am not doing any of the house cleaning that I would usually do. _____
7. Have difficulty doing handwork, for example, turning faucets, using kitchen gadgets, sewing, carpentry. _____
8. Am not doing any of the clothes washing that I would usually do. _____
9. Am not doing heavy work around the house _____
10. Have given up taking care of personal or household business affairs, for example, paying bills, banking, working on budget. _____

Please check here if none apply _____

RP

This group of statements has to do with activities you usually doing your free time. These activities are things that you might do for relaxation, to pass the time, or for entertainments. Please check **only** those statements that you are **sure** describe you today, and are related to your pain or injury.

1. Do hobbies and recreation for shorter periods of time. _____
2. Am going out for entertainment less often. _____
3. Am cutting down on some of my usual inactivity recreation and pastimes, for example, watching TV, playing cards, reading. _____
4. Am not doing any of my usual inactivity recreation and pastimes, for example, watching TV, playing cards, reading. _____
5. AM doing more inactive pastimes in place of my other usual activities. _____
6. Am doing fewer community activities. _____
7. Am cutting down on some of my usual physical recreation or activities. _____
8. Am not doing any of my usually physical recreation or activities. _____

Please check here if none apply _____

PLEASE CHECK ONLY THOSE STATEMENTS THAT YOU ARE SURE DESCRIBE YOU TODAY AND ARE RELATED TO YOUR PAIN OR INJURY.

SR

1. Spend much of the day lying down in order to rest. _____
2. Sit during much of the day. _____
3. Am sleeping or dozing most of the time—day and night. _____
4. Lie down more often during the day in order to rest. _____
5. Sit around half-asleep. _____
6. Sleep less at night, for example, wake up to early, don't fall. asleep for a long time, awaken frequently. _____
7. Sleep or nap more during the day. _____

Please check here if none apply _____

SI

1. Am going out less to visit people. _____
2. Am not going out to visit people at all. _____
3. Am showing less interest in other people's problems, for example, don't listen when they tell me about their problems, don't offer to help. _____
4. Often act irritable toward those around me, for example, snap at people give sharp answers, criticize easily. _____
5. Am showing less affection. _____
6. Am doing fewer social activities with groups of people. _____
7. Am cutting down the length of visits with friends. _____
8. Am avoiding social visits from friends. _____
9. Have decreased sexual activity. _____
10. Often express concern over what might be happening to my health. _____
11. Talk less with those around me. _____
12. Make many demands, for example, insist that people do things for me, tell them how to do things. _____
13. Stay alone much of the time. _____
14. Act disagreeable to family members, for example, I act spiteful, I am stubborn. _____
15. Have frequent outbursts of anger at family members, for example, strike at them, Scream, throw things at them. _____
16. Isolate myself as much as I can from the rest of the family. _____
17. Pay less attention to the children. _____
18. Refuse contact with family members, for example, turn away from them. _____
19. Am not doing things I usually do to take care of the children or the family. _____
20. AM not joking with family members as I usually do. _____

Please check here if none apply _____

EB

1. Say how bad or useless I am, for example, that I am a burden to others. _____
2. Laugh or cry suddenly. _____
3. Often moan and groan in pain or discomfort. _____
4. Have attempted suicide. _____
5. Act nervous or restless. _____
6. Keep rubbing or holding areas of my body that hurt or are uncomfortable. _____
7. Act irritable and impatient with myself, for example, talk badly about myself, swear at myself, blame myself for things that happen. _____
8. Talk about the future in a hopeless way. _____
9. Get sudden frights. _____

Please check here if none apply _____

AB

1. Have more minor accidents, for example, drop things, trip and fall, bump into things. _____
2. React slowly to things that are said or done. _____
3. Am confused and start several actions at a time. _____
4. Do not finish things I start. _____
5. Have difficult reasoning and solving problems, for example, making plans, making decisions, learning new things. _____
6. Sometimes behave as if I am confused or disoriented in place or time, for example, where I am, who is around, directions, what day it is. _____
7. Forget a lot, for example, things that happened recently, where I put things, appointments. _____
8. Do not keep my attention on any activity for long. _____
9. Make more mistakes than usual. _____
10. Have difficulty doing activities involving concentration and thinking. _____

Please check here if none apply _____

W

The next group of statements has to do with <u>any work you usually do other than managing the home</u>. By this we mean anything that you regard as work that you do on a regular basis.

Do you work outside of the home? _____ Yes _____ No

⇒ IF YOU ANSWERED **YES**, GO ON TO THE QUESTIONS BELOW.

⇒ IF YOU ANSWERED **NO**:

ARE YOU RETIRED?	_____ YES	_____ NO
IF YOU ARE RETIRED, WAS YOUR RETIREMENT RELATED TO YOUR HEALTH?	_____ YES	_____ NO
IF YOU ARE NOT RETIRED, BUT ARE NOT WORKING, IS THIS RELATED TO YOUR HEALTH?	_____ YES	_____ NO

⇒ NOW **SKIP** TO THE QUESTIONS BELOW.

IF YOU ARE NOT WORKING AND IT IS **<u>NOT</u>** BECAUSE OF YOUR HEALTH, PLEASE SKIP THIS SECTION.

Now consider the work you do and check *only* those statements that you are *sure* describe you <u>today</u> and <u>are related to your pain or injury.</u> (If today is a Saturday or Sunday or some other day that you usually have off, please respond as if today were a working day).

1. Am not working at all (If you checked this statement, questionnaire is finished) _____
2. Am doing part of my job at home. _____
3. Am not accomplishing as much as usual at work _____
4. Often act irritable toward work associates, for example, snap at them, give sharp answers, criticize easily. _____
5. Am working shorter hours. _____
6. Am doing only light work. _____
7. Work only for short periods of time or take frequent rests. _____
8. Am working at my usual job, but with some changes, for example, using different tools or special aids, trading some tasks with other workers. _____
9. Do not do my job as carefully and accurately as usual. _____