

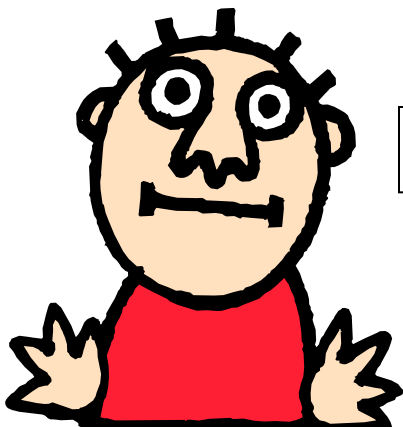


The Barolat Institute Pain Evaluation Questionnaire

Thank you for filling out this
questionnaire.

This information will be
invaluable in helping us
understand your problem.

Please be as thorough as
possible in answering all the
appropriate questions.



PLEASE HELP US HELP YOU !!!!!

The Barolat Institute Pain Evaluation Questionnaire

Name _____ Date _____

Please score your pain for the various body parts listed below (score all body parts)

Circle the appropriate responses

Average Pain

Pain Level

Face	0	1	2	3	4	5	6	7	8	9	10
Head	0	1	2	3	4	5	6	7	8	9	10
Neck	0	1	2	3	4	5	6	7	8	9	10
Shoulder Blade	0	1	2	3	4	5	6	7	8	9	10
Shoulder	0	1	2	3	4	5	6	7	8	9	10
Chest	0	1	2	3	4	5	6	7	8	9	10
Back Thoracic	0	1	2	3	4	5	6	7	8	9	10
Back Lumbar	0	1	2	3	4	5	6	7	8	9	10
Abdomen	0	1	2	3	4	5	6	7	8	9	10
Private Parts	0	1	2	3	4	5	6	7	8	9	10
Arm(s)	0	1	2	3	4	5	6	7	8	9	10
Leg(s)	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

Worst Pain

Pain Level

Face	0	1	2	3	4	5	6	7	8	9	10
Head	0	1	2	3	4	5	6	7	8	9	10
Neck	0	1	2	3	4	5	6	7	8	9	10
Shoulder Blade	0	1	2	3	4	5	6	7	8	9	10
Shoulder	0	1	2	3	4	5	6	7	8	9	10
Chest	0	1	2	3	4	5	6	7	8	9	10
Back Thoracic	0	1	2	3	4	5	6	7	8	9	10
Back Lumbar	0	1	2	3	4	5	6	7	8	9	10
Abdomen	0	1	2	3	4	5	6	7	8	9	10
Private Parts	0	1	2	3	4	5	6	7	8	9	10
Arm(s)	0	1	2	3	4	5	6	7	8	9	10
Leg(s)	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

The Barolat Institute Pain Evaluation Questionnaire

Name _____

The Questions In This Section Pertain To Your WORST Pain And/Or The Pain You Are Trying To Address In This Consultation
(if you have a second worst pain area fill the next page as well)

What body part are you addressing in this section?

- a. Head
- b. Face
- c. Neck
- d. Upper back (at shoulder blades level)
- e. Midback (above beltline)
- f. Low back (below beltline)
- g. Shoulder(s)
- h. Chest
- i. Abdomen
- j. Flank
- k. Private parts
- l. Arm(s)
- m. Leg(s)
- n. Other _____

How frequent is your pain?

- a. Constant
- b. Not constant: every day frequently
- c. Not constant: every day infrequently
- d. Not constant: not every day

How bad is the pain? (at its worst)

- a. Excruciating
- b. Severe
- c. Moderate
- d. Mild

How long have you had the pain?

- a. Less than a month
- b. 1-6 months
- c. 6-12 months
- d. More than one year

How bad is the pain? (at its least)

- a. Excruciating
- b. Severe
- c. Moderate
- d. Mild

Do you have any of the following in the pain area?

- a. Swelling
- b. Change in color
- c. Change in temperature
- d. Pain/discomfort even to light touch
- e. Air blowing causes pain/discomfort
- f. The water in the shower causes pain/discomfort
- g. Sheets in bed bother me

Describe your pain (select up to 3 choices and circle the order of importance)

- 1 2 3 Sharp
- 1 2 3 Dull
- 1 2 3 Aching
- 1 2 3 Stabbing
- 1 2 3 Shooting
- 1 2 3 Burning
- 1 2 3 Tearing
- 1 2 3 Lightening bolt

How is your pain at night?

- a. No pain
- b. Much less than during the day
- c. Less than during the day
- d. Just as bad as during the day

Does your pain wake you up at night?

- a. Never
- b. Seldom
- c. Often
- d. Always

Are you numb in the area of worst pain?

- a. Yes constantly
- b. Yes at times
- c. No

The Barolat Institute Pain Evaluation Questionnaire

Name _____

**The Questions In This Section Pertain To Your SECOND WORST Pain
(If you have one)**

What body part are you addressing in this section?

- a. Head
- b. Face
- c. Neck
- d. Upper back (at shoulder blades level)
- e. Midback (above beltline)
- f. Low back (below beltline)
- g. Shoulder(s)
- h. Chest
- i. Abdomen
- j. Flank
- k. Private parts
- l. Arm(s)
- m. Leg(s)
- n. Other _____

How frequent is your pain?

- a. Constant
- b. Not constant: every day frequently
- c. Not constant: every day infrequently
- d. Not constant: not every day

**How bad is the pain?
(at its worst)**

- a. Excruciating
- b. Severe
- c. Moderate
- d. Mild

How long have you had the pain?

- a. Less than a month
- b. 1-6 months
- c. 6-12 months
- d. More than one year

**How bad is the pain?
(at its least)**

- a. Excruciating
- b. Severe
- c. Moderate
- d. Mild

Do you have any of the following in the pain area?

- a. Swelling
- b. Change in color
- c. Change in temperature
- d. Pain/discomfort even to light touch
- e. Air blowing causes pain/discomfort
- f. The water in the shower causes pain/discomfort
- g. Sheets in bed bother me

Describe your pain (select up to 3 choices and circle the order of importance)

- 1 2 3 Sharp
- 1 2 3 Dull
- 1 2 3 Aching
- 1 2 3 Stabbing
- 1 2 3 Shooting
- 1 2 3 Burning
- 1 2 3 Tearing
- 1 2 3 Lightening bolt

How is your pain at night?

- a. No pain
- b. Much less than during the day
- c. Less than during the day
- d. Just as bad as during the day

Does your pain wake you up at night?

- a. Never
- b. Seldom
- c. Often
- d. Always

Are you numb in the area of worst pain?

- a. Yes constantly
- b. Yes at times
- c. No

If your main problem is HEADACHES/PAIN IN THE FACE
Fill This Section

Where is your worst pain?

(Circle no more than 3 choices)

- a. Neck
- b. Back of the head
- c. Front of the head
- d. Forehead
- e. Jaw
- f. Cheekbone
- g. Ear
- h. Mouth

Where is the distribution of your pain?

- a. Only on one side
- b. Both sides
- c. In the center

How large is the area of your worst pain?

- a. A quarter
- b. A fist
- c. Two fists
- d. Larger than two fists

If your main problem is pain in OTHER PARTS OF THE BODY (including NECK and BACK)
Fill This Section

Where is your worst pain? (Circle no more than 3 choices)

- a. Neck
- b. Upper back (at shoulder blades level)
- c. Midback (above beltline)
- d. Low back (below beltline)
- e. Shoulder(s)
- f. Chest
- g. Abdomen
- h. Flank
- i. Private parts

Where is the distribution of your pain?

- a. Only on one side
- b. Both sides
- c. In the center

How large is the area of your worst pain?

- a. A quarter
- b. A fist
- c. Two fists
- d. Larger than two fists

For patients who have had previous surgery related to the existing problem (except spine surgery)

Fill This Section

How many surgeries have you had? (Count only the ones meant to address your current pain problem)

- a. 1
- b. 2
- c. More than 2

Did any of the surgeries help you with your current pain for more than 6 months?

- a. Yes
- b. Maybe
- c. No

Was your pain permanently worse after one of the surgeries?

- a. Yes
- b. No
- c. Hard to tell

For patients who have had previous SPINE surgery related to the existing problem

Fill This Section

How many surgeries have you had? (Count only the ones meant to address your current pain problem)

- a. 1
- b. 2
- c. More than 2

Did any of the surgeries help you with your current arm / leg pain for more than 6 months?

- a. Yes
- b. Maybe
- c. No
- d. N/A

Did any of the surgeries help you with your current neck/back pain for more than 6 months?

- a. Yes
- b. Maybe
- c. No
- d. N/A

Was your arm / leg/neck / back pain permanently worse after one of the surgeries?

- a. Yes
- b. No
- c. Hard to tell

The Barolat Institute
Pain Evaluation Questionnaire: Functional Assessment

Name _____

What impact does the pain have on your life?	
Minimal	Moderate
What was your activity level prior to the onset of the pain problem? <input type="checkbox"/> Sedentary <input type="checkbox"/> Moderately active <input type="checkbox"/> Very active	What is your activity level now? <input type="checkbox"/> Sedentary <input type="checkbox"/> Moderately active <input type="checkbox"/> Very active
Were you actively involved with sports prior to the pain problem? <input type="checkbox"/> Yes, Very Much <input type="checkbox"/> Yes, Moderately <input type="checkbox"/> Yes, Minimally <input type="checkbox"/> No	Are you involved with sports now? <input type="checkbox"/> Yes, Very Much <input type="checkbox"/> Yes, Moderately <input type="checkbox"/> Yes, Minimally <input type="checkbox"/> No
How do you spend most of your day? <input type="checkbox"/> At home in bed <input type="checkbox"/> At home on the couch <input type="checkbox"/> At home actively performing chores <input type="checkbox"/> I go out a few hours and then at home <input type="checkbox"/> I am out at least 8 hours per day	
What hobbies did you have prior to the pain problem?	What hobbies do you have now?
Work prior to pain problem <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Disability <input type="checkbox"/> Other	Work now <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Disability <input type="checkbox"/> Other
What are the activities that you would like to perform if the treatment is successful in reducing your pain? (Pick 3 and be realistic) <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	