Connecticut Children's MEDICAL CENTER

Division of Pain Medicine

WWW.CONNECTICUTCHILDRENS.ORG

NEW PATIENT QUESTIONNAIRE

Patient ID

Connecticut Children's #:

Name:

Primary Care Provider: _____ Phone:_____ Fax:_____

Referring Provider:_____ Phone:_____ Fax:_____

Referring Provider Specialty: _____

Reason For Referral: _____

Completed New Patient Packets must be returned within two weeks of scheduling your appointment. Your packet is due on _____ or we reserve the right to reschedule your appointment. Note: Please contact all pertinent medical or school providers to obtain consent for medical records and tests which **MUST** be forwarded to us in advance of your child's appointment. If you have any questions about the forms, please call our office at **860-837-5207**.

Patient Name _____

Gender: ☐ M ☐ F Date of Birth:_____ / _____ / _____ Age:_____ Grade:_____

Allergies: Medication/Food/Environment: ☐ Yes ☐ No (please list) _____

Address:_____ City:_____ State:_____ Zip: _____

Home phone: _____ Cell phone: _____

Parents names (or Guardian):

Mother: _____ Work phone:_____ Cell phone:_____

Father: _____ Work phone:_____ Cell phone:_____

Current marital status: ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed ☐ Remarried ☐ Other: _____

Legal Guardian: _____ Home phone:_____ Work phone:_____ Cell phone:_____

Child's race (check all that apply): ☐ Black/African American ☐ White ☐ Asian ☐ American Indian/Alaska Native
☐ Native Hawaiian or Other Pacific Islander ☐ Other_____

Child's ethnicity: ☐ Hispanic ☐ Non-Hispanic

Primary Language: _____ Do you need a medical interpreter? ☐ Yes ☐ No

Please list child's known physical and mental health problems: _____

_____

_____

_____

When did your child's pain problem begin? Month: _____ Year: _____

Where is your child having pain? ☐ Head ☐ Abdominal/Pelvic/Flank ☐ Back ☐ Joint ☐ Leg ☐ Foot/Ankle ☐ Arm ☐ Chest
☐ Neck/Shoulder ☐ Hand/Wrist ☐ Hip ☐ Face

Please rank the top three pain locations based on severity: 1)_____ 2)_____ 3)_____

Patient ID

Connecticut Children's #:

Name:

NEW PATIENT QUESTIONNAIRE CON'T

Other Associated Symptoms: _____

Are you concerned that your child has symptoms of anxiety or depression? ☐ Yes ☐ No *(Please Explain)* _____

Does your child participate in any exercise or sports? _____

At the present time, does your child's pain limit him/her? (check all that apply)
Mild activities: ☐ Walking one block ☐ Climbing one flight of stairs ☐ Sitting or standing
Moderate activities: ☐ Climbing several flights of stairs ☐ Bending, stooping, lifting ☐ Walking several blocks
Vigorous activity: ☐ Running ☐ Biking ☐ Lifting heavy objects ☐ Participating in strenuous sports

Has your child used any of these treatments for pain?

Physical Therapy: ☐ Yes ☐ No	Occupational Therapy: ☐ Yes ☐ No	Aquatic Therapy: ☐ Yes ☐ No
Tens Unit: ☐ Yes ☐ No	Biofeedback: ☐ Yes ☐ No	Massage Therapy: ☐ Yes ☐ No
Relaxation Training: ☐ Yes ☐ No	Chiropractor: ☐ Yes ☐ No	Acupuncture: ☐ Yes ☐ No
Meditation: ☐ Yes ☐ No	Guided Imagery or Hypnosis: ☐ Yes ☐ No	Herbal Medicine: ☐ Yes ☐ No
Reike: ☐ Yes ☐ No	Yoga: ☐ Yes ☐ No	

Does your child have a good appetite? ☐ Yes ☐ No
Please note weight changes (if applicable) ☐ Weight Gain _____ (pounds) ☐ Weight Loss _____ (pounds)

Does your child have problems with: Diarrhea: ☐ Yes ☐ No Constipation: ☐ Yes ☐ No

Does your child have difficulty falling asleep or staying asleep at night? *Please describe:*_____
_____

Does your child nap during the day? ☐ Yes ☐ No *(If yes for how long?)* _____

For girls only: Is your pain associated with or worsened by your menstrual cycle? ☐ Yes ☐ No

SCHOOL INFORMATION

School Name: _____ Grade: _____

Is your child starting a new school this year? ☐ Yes ☐ No

Does your child attend school: ☐ Full time ☐ Part time ☐ Homebound with tutor ☐ Not attending
If child has a modified school plan/schedule please provide name of ordering physician _____

During the most recent school year, how many days has your child missed school due to pain?
☐ None ☐ one day only ☐ 2-3 days ☐ 4-5 days ☐ 6-10 days ☐ 11-15 days ☐ 16-20 days ☐ More than 20 days

How would you describe your child's academic performance?
Current academic year grades are mostly: ☐ A's ☐ B's ☐ C's ☐ D's ☐ F's
Last academic year grades are mostly: ☐ A's ☐ B's ☐ C's ☐ D's ☐ F's

Is your child able to keep up with their homework? ☐ Yes ☐ No

Patient ID

Connecticut Children's #:

Name:

NEW PATIENT QUESTIONNAIRE CON'T

If your child has a specialized academic program please describe the accommodations:

☐ 504 Plan _____

☐ Individualized Educational Plan (IEP) _____

☐ Other _____

Please send any of the above information and/or psychological educational testing reports to our office prior to your child's appointment.

Is there anything else you would like to tell us about your child? _____

_____

_____

Form completed by: _____ ***Date completed:*** _____

Office Use Only: Date of call/intake: ____ / ____ / _____ ***Spoke with:*** _____

PROVIDER INFORMATION

Please provide contact information for all medical, mental health, physical therapy, and school providers (psychologist/social worker/guidance counselor/nurse) that you are currently working with in order for us to send our evaluation summary and treatment recommendations:

Provider Name: _____ Organization/Specialty: _____

Address: _____

_____

Phone number: _____ Fax Number: _____

Date of Last Appointment:_____ / _____ / _____ Date of Next appointment:_____ / _____ / _____

Provider Name: _____ Organization/Specialty: _____

Address: _____

_____

Phone number: _____ Fax Number: _____

Date of Last Appointment:_____ / _____ / _____ Date of Next appointment:_____ / _____ / _____

Provider Name: _____ Organization/Specialty: _____

Address: _____

_____

Phone number: _____ Fax Number: _____

Date of Last Appointment:_____ / _____ / _____ Date of Next appointment:_____ / _____ / _____

Patient ID

Connecticut
Children's #:

Name:

NEW PATIENT QUESTIONNAIRE CON'T

Provider Name: _____ Organization/Specialty: _____

Address: _____

_____

Phone number: _____ Fax Number: _____

Date of Last Appointment:_____ / _____ / _____ Date of Next appointment:_____ / _____ / _____

Provider Name: _____ Organization/Specialty: _____

Address: _____

_____

Phone number: _____ Fax Number: _____

Date of Last Appointment:_____ / _____ / _____ Date of Next appointment:_____ / _____ / _____

CONNECTICUT CHILDREN'S MEDICAL CENTER & SPECIALTY GROUP MEDICATION LIST AND RECONCILIATION FORM

Name: _____ Allergies: _____

☐ Patient does not take any medications _____ Provider Name: _____

MY MEDICATIONS: How Taken (Route) Pill/Liquid-including concentration/Inhaled/Topical/g-tube/injections

Date	Medication Name	Dose	Route-See above	Frequency	Reason Taking	Prescribed By	RN/Provider Initials

No medication changes (date/initial):_____ / _____ / _____, _____ Pharmacy/Phone #:_____

☐ Patient/Family does not know the names and doses of their medication

Patient/Parent/Guardian Signature: _____ Date/Time:_____ / _____ / _____, _____

Provider Signature: _____ Date/Time:_____ / _____ / _____, _____

Patient/Parent/Guardian Signature: _____ Date/Time:_____ / _____ / _____, _____

Provider Signature: _____ Date/Time:_____ / _____ / _____, _____

Patient/Parent/Guardian Signature: _____ Date/Time:_____ / _____ / _____, _____

Provider Signature: _____ Date/Time:_____ / _____ / _____, _____

Connecticut Children's MEDICAL CENTER

Division of Pain Medicine

WWW.CONNECTICUTCHILDRENS.ORG

Patient ID

Connecticut Children's #:

Name:

PARENT PACKET

Parent name (or Guardian): _____

This packet contains the following forms for one parent to complete and return:

- ☐ *New Patient Questionnaire*
- ☐ *Pain Burden Interview*
- ☐ *'What your child can do' form (FDI-P)*
- ☐ *'When your child is in pain' form (PCS-P)*

  15-584/2 Rev. 2-16

Connecticut Children's MEDICAL CENTER

Division of Pain Medicine

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Patient ID

Connecticut Children's #:

Name:

PAIN BURDEN INTERVIEW – PARENT REPORT

Patient Name _____ Parent (or Guardian) Name _____

Date Completed _____

Please think about your child's pain when completing this form. **In the last month:**

1. How many days has your child had any pain? ..... ☐ *0-None* ☐ *1-A Few* ☐ *2-Some* ☐ *3-Many* ☐ *4-Every*

2. How many nights has your child slept poorly (trouble falling asleep, waking up during sleep) because of pain? ..... ☐ *0-None* ☐ *1-A Few* ☐ *2-Some* ☐ *3-Many* ☐ *4-Every*

3. How many days has your child had trouble taking care of himself/herself (dressing, going to the bathroom, showering) because of pain? ..... ☐ *0-None* ☐ *1-A Few* ☐ *2-Some* ☐ *3-Many* ☐ *4-Every*

4. How many days has your child missed school/work because of pain? ..... ☐ *0-None* ☐ *1-A Few* ☐ *2-Some* ☐ *3-Many* ☐ *4-Every*

5. How many days has your child left school/work early because of pain? ..... ☐ *0-None* ☐ *1-A Few* ☐ *2-Some* ☐ *3-Many* ☐ *4-Every*

6. How many days has your child been unable to do things s/he enjoys because of pain? ..... ☐ *0-None* ☐ *1-A Few* ☐ *2-Some* ☐ *3-Many* ☐ *4-Every*

7. How many days has your child felt sad, mad, or upset because of pain? ..... ☐ *0-None* ☐ *1-A Few* ☐ *2-Some* ☐ *3-Many* ☐ *4-Every*

0 = None 1 = A Few 2 = Some 3 = Many 4 = Every **Total:** _____

Connecticut Children's MEDICAL CENTER

Division of Pain Medicine

WWW.CONNECTICUTCHILDRENS.ORG

Patient ID

Connecticut Children's #:

Name:

WHAT YOUR CHILD CAN DO (FDI-PARENT)

Patient Name _____ Parent (or Guardian) Name _____

Date of visit _____

When people are sick or having pain it is sometimes difficult for them to do their regular activities. In the last few days, would your child have had any physical trouble or difficulty doing these activities?

1. Walking to the bathroom? ..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

2. Walking up stairs ..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

3. Doing something with a friend ..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*
(For example, playing a game)

4. Doing chores at home ..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

5. Eating regular meals ..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

6. Being up all day without a nap or rest..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

7. Riding the school bus or traveling in the car ..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

REMEMBER, YOU ARE BEING ASKED ABOUT DIFFICULTY DUE TO PHYSICAL HEALTH.

8. Being at school all day..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

9. Doing the activities in gym class ..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*
(or playing sports)

10. Reading or doing homework..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

11. Watching TV..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

12. Walking the length of a football field..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

13. Running the length of a football field ..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

14. Going shopping..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

15. Getting to sleep at night and staying asleep ..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

0 = No Trouble *1 = A Little Trouble* *2 = Some Trouble* *3 = A Lot of Trouble* *4 = Impossible* **FDI Total: _____**

Connecticut Children's MEDICAL CENTER

Division of Pain Medicine

WWW.CONNECTICUTCHILDRENS.ORG

WHEN YOUR CHILD IS IN PAIN (PCS-P)

Patient ID

Connecticut Children's #:

Name:

Patient Name:_____ Parent (or Guardian) Name:_____

Date of visit:_____ Patient Age:_____ Patient Gender: ☐ Male ☐ Female

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 your child is in pain. Below are 13 sentences of different thoughts and feelings. Using the following scale, please indicate the degree to which you have these thoughts and feelings when your child is in pain.

	Not at all	Mildly	Moderately	Severely	Extremely
1. When my child is in pain, I worry all the time about whether the pain will end	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
2. When my child is in pain, I feel I can't go on like this much longer	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
3. When my child is in pain, it's terrible and I think it's never going to get better	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
4. When my child is in pain, it's awful and I feel it overwhelms me.	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
5. When my child is in pain, I can't stand it anymore	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
6. When my child is in pain, I become afraid that the pain will get worse.	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
7. When my child is in pain, I keep thinking of other painful events.	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
8. When my child is in pain, I want the pain to go away	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
9. When my child is in pain, I can't keep it out of my mind.	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
10. When my child is in pain, I keep thinking About how much he/she is suffering	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
11. When my child is in pain, I keep thinking about how much I want the pain to stop	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
12. When my child is in pain, there is nothing I can do to stop the pain.	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
13. When my child is in pain, I wonder whether something serious may happen.	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*

0 = Not at all 1 = Mildly 2 = Moderately 3 = Severely 4 = Extremely **PCS Total: _____**

Connecticut Children's MEDICAL CENTER

Division of Pain Medicine

WWW.CONNECTICUTCHILDRENS.ORG

Patient ID

Connecticut Children's #:

Name:

CHILD PACKET

For Children ages 8 and above

Child Name: _____

This packet contains the following forms for the child/patient to complete:

- ☐ *Adolescent Pediatric Pain Tool (APPT) drawing*
- ☐ *Pain Numeric Rating Scale*
- ☐ *Pain Burden Interview*
- ☐ *'What can you do' form (FDI)*
- ☐ *'When I am in pain' form (PCS-C)*

 15-584/9 New 11-15

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Patient ID

Connecticut Children's #:

Name:

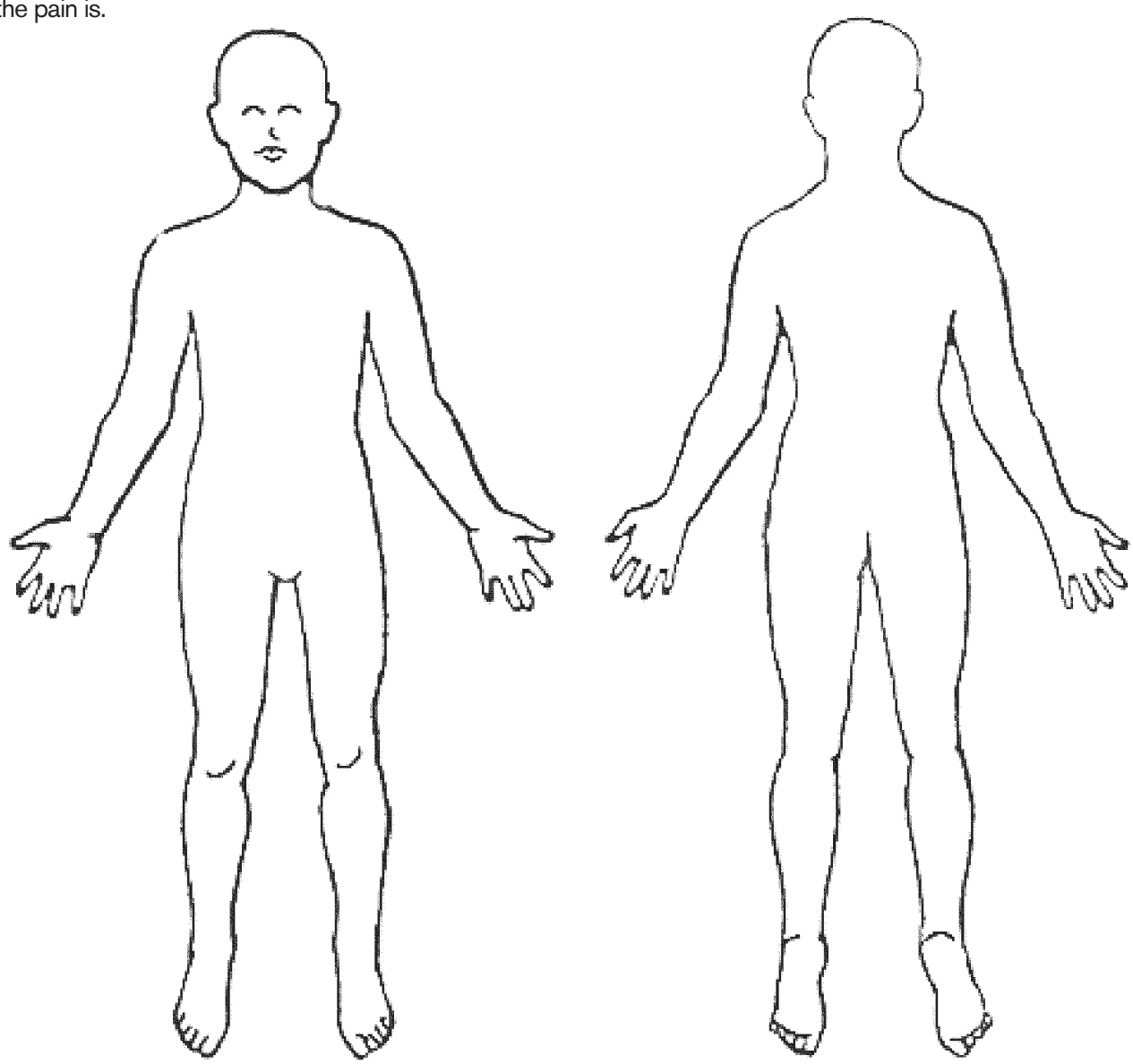
ADOLESCENT PEDIATRIC PAIN TOOL (APPT)

Patient Name _____ Parent (or Guardian) Name _____

Date Completed _____

INSTRUCTIONS:

1. Color in the areas on these drawings to show where you have pain. Make the marks as big or small as the place where the pain is.



Connecticut Children's MEDICAL CENTER

Division of Pain Medicine

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Patient ID

Connecticut Children's #:

Name:

PAIN NUMERIC RATING SCALE

Patient Name _____ Parent (or Guardian) Name _____

Date Completed _____

Please answer the following questions using a scale of 0 to 10.
A score of **"0"** would be no pain at all and a score of **"10"** would be the strongest or the worst pain imaginable.

1. How would you rate your **CURRENT** pain?

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										**THE STRONGEST OR WORST PAIN YOU CAN IMAGINE**

2. How would you rate your **USUAL** level of pain during the last week?

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										**THE STRONGEST OR WORST PAIN YOU CAN IMAGINE**

3. How would you rate your **LOWEST** level of pain during the last week?

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										**THE STRONGEST OR WORST PAIN YOU CAN IMAGINE**

4. How would you rate your **WORST** level of pain during the last week?

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										**THE STRONGEST OR WORST PAIN YOU CAN IMAGINE**

Connecticut Children's MEDICAL CENTER

Division of Pain Medicine

WWW.CONNECTICUTCHILDRENS.ORG

Patient ID

Connecticut Children's #:

Name:

PAIN BURDEN INTERVIEW – CHILD REPORT

Patient Name _____ Parent (or Guardian) Name _____

Date Completed _____

Think about your pain. **In the last month:**

1. How many days have you had any pain? ☐ *0-None* ☐ *1-A Few* ☐ *2-Some* ☐ *3-Many* ☐ *4-Every*

2. How many nights have you slept poorly (trouble falling asleep, waking up during sleep) because of pain? ☐ *0-None* ☐ *1-A Few* ☐ *2-Some* ☐ *3-Many* ☐ *4-Every*

3. How many days have you had trouble taking care of yourself (dressing, going to the bathroom, showering) because of pain? ☐ *0-None* ☐ *1-A Few* ☐ *2-Some* ☐ *3-Many* ☐ *4-Every*

4. How many days have you missed school/work because of pain? ☐ *0-None* ☐ *1-A Few* ☐ *2-Some* ☐ *3-Many* ☐ *4-Every*

5. How many days have you left school/work early because of pain? ☐ *0-None* ☐ *1-A Few* ☐ *2-Some* ☐ *3-Many* ☐ *4-Every*

6. How many days have you been unable to do things you enjoy because of pain? ☐ *0-None* ☐ *1-A Few* ☐ *2-Some* ☐ *3-Many* ☐ *4-Every*

7. How many days have you felt sad, mad, or upset because of pain? ☐ *0-None* ☐ *1-A Few* ☐ *2-Some* ☐ *3-Many* ☐ *4-Every*

0 = None 1 = A Few 2 = Some 3 = Many 4 = Every **Total:** _____

Connecticut Children's MEDICAL CENTER

Division of Pain Medicine

WWW.CONNECTICUTCHILDRENS.ORG

Patient ID

Connecticut Children's #:

Name:

WHAT YOU CAN DO (FDI – PATIENT)

Patient Name _____ Parent (or Guardian) Name _____

Date of visit _____

When people are sick or having pain it is sometimes difficult for them to do their regular activities. In the last few days, have you had any physical trouble or difficulty doing these activities?

1. Walking to the bathroom? ..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

2. Walking up stairs ..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

3. Doing something with a friend ..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*
   (For example, playing a game)

4. Doing chores at home ..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

5. Eating regular meals ..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

6. Being up all day without a nap or rest..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

7. Riding the school bus or traveling in the car ..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

REMEMBER, YOU ARE BEING ASKED ABOUT DIFFICULTY DUE TO PHYSICAL HEALTH.

8. Being at school all day..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

9. Doing the activities in gym class ..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*
   (or playing sports)

10. Reading or doing homework..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

11. Watching TV..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

12. Walking the length of a football field..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

13. Running the length of a football field ..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

14. Going shopping..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

15. Getting to sleep at night and staying asleep ..... ☐ *0-No Trouble* ☐ *1-A Little Trouble* ☐ *2-Some Trouble* ☐ *3-A Lot of Trouble* ☐ *4-Impossible*

0 = No Trouble *1 = A Little Trouble* *2 = Some Trouble* *3 = A Lot of Trouble* *4 = Impossible* **FDI Total: _____**

Connecticut Children's MEDICAL CENTER

Division of Pain Medicine

WWW.CONNECTICUTCHILDRENS.ORG

WHEN I AM IN PAIN PCS-C

Patient ID

Connecticut Children's #:

Name:

Patient Name:_____ Parent (or Guardian) Name:_____

Date of visit:_____ Patient Age:_____ Patient Gender: ☐ Male ☐ Female

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 your child is in pain. Below are 13 sentences of different thoughts and feelings. Using the following scale, please indicate the degree to which you have these thoughts and feelings when your child is in pain.

	Not at all	Mildly	Moderately	Severely	Extremely
1. When I am in pain, I worry all the time about whether the pain will end	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
2. When I am in pain, I feel I can't go on like this much longer	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
3. When I am pain, it's terrible and I think it's never going to get better	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
4. When I am in pain, it's awful and I feel it overwhelms me	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
5. When I am in pain, I can't stand it anymore	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
6. When I am in pain, I become afraid that the pain will get worse	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
7. When I am in pain, I keep thinking of other painful events	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
8. When I am in pain, I want the pain to go away	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
9. When I am in pain, I can't keep it out of my mind	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
10. When I am in pain, I keep thinking about how much it hurts	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
11. When I am in pain, I keep thinking about how much I want the pain to stop	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
12. When I am in pain, there is nothing I can do to stop the pain	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*
13. When I am in pain, I wonder whether something serious may happen	☐ *0*	☐ *1*	☐ *2*	☐ *3*	☐ *4*

0 = Not at all 1 = Mildly 2 = Moderately 3 = Severely 4 = Extremely **PCS Total: _____**