Modern Health

Pain and Fatigue Screening

Please complete the entire form and complete the calculations prior to your appointment

For each of the questions, answer how you have been feeling over the last 4 weeks. Section 3 includes a one week pain diary.

Date (dd/mm/yyyy)

Patient Ref

Title

- ◯ Mr
- ◯ Mrs
- ◯ Miss
- ◯ Ms

First Name

Surname

Sex

- ◯ F
- ◯ M

Date of birth

Section 1 - Symptom Severity

General

	Never - 0	1	2	3	4	Always - 5
1.1 Do you suffer from diarrhoea or IBS?	◯	◯	◯	◯	◯	◯
1.2 Do you experience recurrent flu-like symptoms?	◯	◯	◯	◯	◯	◯
1.3 Do you experience dizziness or weakness upon standing?	◯	◯	◯	◯	◯	◯
1.4 Have you experienced unexplained marked weight changes?	◯	◯	◯	◯	◯	◯
1.5 Do you have a recurrent sore throat?	◯	◯	◯	◯	◯	◯
1.6 Have you developed new sensitivities to food, medications and/ or chemicals since being unwell?	◯	◯	◯	◯	◯	◯
1.7 Do you experience tender lymph nodes, especially at the sides of the neck and under arms?	◯	◯	◯	◯	◯	◯

	x 0	x 1	x 2	x 3	x 4	x 5
	= 0	=	=	=	=	=

Section 1 - General Total:

continued over . . . .

Sensations

	Never - 0	1	2	3	4	Always - 5
1.8 Do you have pain in muscles and/or joints or headaches?	○	○	○	○	○	○
1.9 Do you feel a burning sensation (e.g. stinging nettles) in your areas of pain?	○	○	○	○	○	○
1.10 Do you have a tingling or pricking sensation in the area of your pain (e.g. feeling like crawling ants or electrical tingling)?	○	○	○	○	○	○
1.11 Is light touching (e.g. clothing, bedding) in this area painful?	○	○	○	○	○	○
1.12 Do you have sudden pain attacks in the areas of your pain (e.g. feeling like an electric shock)?	○	○	○	○	○	○
1.13 Is cold or heat (bath water) painful in your areas of pain?	○	○	○	○	○	○
1.14 Do you suffer from a sensation of numbness in the your painful areas?	○	○	○	○	○	○
1.15 Does slight pressure in your painful area (e.g. from a finger) cause pain?	○	○	○	○	○	○
1.16 Are you sensitive to light, noise or odours?	○	○	○	○	○	○
1.17 Do you experience erratic body temperature changes?	○	○	○	○	○	○
1.18 Do you have heat/cold intolerance?	○	○	○	○	○	○
1.19 Do you experience hot flushes or sweating episodes?	○	○	○	○	○	○
	x 0	x 1	x 2	x 3	x 4	x 5
	= 0	=	=	=	=	=

Section 1 - Sensations Total: ☐

Fatigue

	Never - 0	1	2	3	4	Always - 5
1.20 Do you experience a loss of physical and mental stamina after exerting yourself or is your fatigue made worse by physical exertion?	○	○	○	○	○	○
1.21 Does it take more than 24 hours to recover to your pre-exertion activity level?	○	○	○	○	○	○
1.22 Do you suffer from persistent, marked fatigue that substantially reduces your activity level?	○	○	○	○	○	○
1.23 Do you suffer from non-restorative sleep, insomnia or hypersomnia (excessive daytime sleepiness or prolonged nighttime sleep) or other sleep disturbance?	○	○	○	○	○	○
1.24 Do you encounter breathlessness with exertion?	○	○	○	○	○	○
1.25 Do you experience muscle weakness?	○	○	○	○	○	○
	x 0	x 1	x 2	x 3	x 4	x 5
	= 0	=	=	=	=	=

Section 1 - Fatigue Total: ☐

continued over . . . .

Thought Processes

	Never - 0	1	2	3	4	Always - 5
1.26 Do you have poor short term memory?	○	○	○	○	○	○
1.27 Do you experience confusion or have difficulty concentrating?	○	○	○	○	○	○
1.28 Do you have difficulty finding or saying the right word?	○	○	○	○	○	○

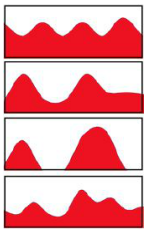
	x 0	x 1	x 2	x 3	x 4	x 5
	= 0	=	=	=	=	=

Section 1 - Thought Processes Total:

Section 2 - Course of Pain

Scoring method: A = 0, B = -1, C = 1, D = 1, E = 0

- ○ Persistent pain with slight fluctuations
- ○ Persistent pain with pain attacks
- ○ Pain attacks without pain between them
- ○ Pain attacks with pain between them
- ○ (This section does not apply to me.)



Section 2 - Course of Pain Total:

Section 3 - Mobility

Scoring method: 1 point for each Yes answer.

	No	Yes
3.1 Can you now (or could you ever) place your hands flat on the floor without bending your knees?	○	○
3.2 Can you now (or could you ever) bend your thumb to touch your forearm?	○	○
3.3 As a child did you contort your body into strange shapes or could you do the splits?	○	○
3.4 As a child or teenager did your shoulder or kneecap dislocate on more than one occasion?	○	○
3.5 Do you consider yourself double-jointed?	○	○

Section 3 - Mobility Total:

Section 4 - Pain Trends

The chart on the following page is to be completed for the week prior to your appointment.

Date	Use the format of: dd/mm/yy
Awakening time	Time in the morning when you woke up
Temp am	Record your temperature as soon as you awaken, while you are still lying down. Also indicate if you feel cold (C), have cold feet (CF), cold hands (CH) and/or if you are stiff (S)
Hours slept	Indicate approximate number of hours you slept (round to the nearest hour)
Sleep quality	Good (G), fair (F) or poor (P); woke up (W) and the number of times you woke (for example “W2” for waking up twice) and record if you know why you woke up, such as to urinate, muscle cramps, nasal congestions, etc.
Pain am / Pain pm	Rate your pain on a scale of 0 to 10 (0 = no pain; 10 = the worst pain you have experienced) in the morning and in the evening
Energy	Indicate your average energy level for the day on a reverse scale of 0 to 10 (0 = full of energy; 10 = being bedridden)
Temp pm	Record your temperature before going to bed. Also indicate if you feel cold (C), have cold feet (CF), cold hands (CH) and/or if you are stiff (S)
Time to sleep	Record as best you can approximately how many hours and/or minutes it took you to fall asleep.

continued over . . . .

One Week Pain Diary

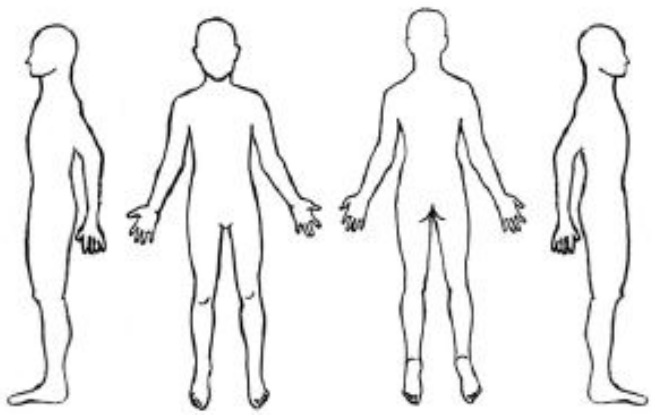
Date	Awakening time	Temp am (°C)	Hours slept	Sleep quality	Pain am (0 - 10)	Temp pm (°C)	Pain pm (0 - 10)	Energy (0 - 10)	Time to sleep
1									
2									
3									
4									
5									
6									
7									
Week Total		/ 7	/ 7		/ 7	/ 7	/ 7	/ 7	/ 7
Daily average		=	=		=	=	=	=	=

Pain Diagram

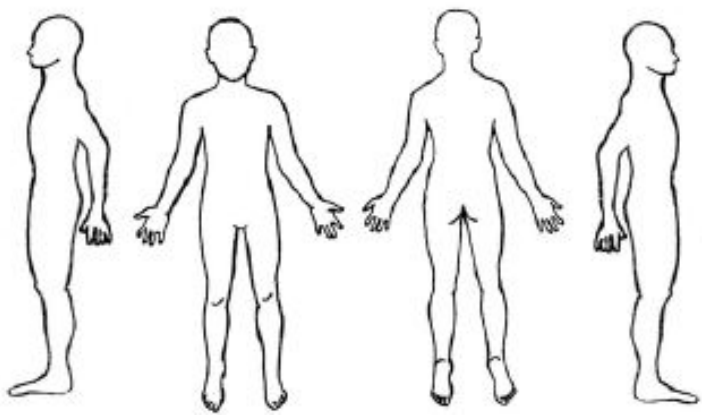
For the week of your pain diary, on the following diagrams, indicate your areas of:

Aching: ===
Stabbing pain: ////
Other pain: ppp
Burning pain: xxx
Pins & needles: ooo
Describe "Other" pain:

Pain on day 1 of pain diary:



Pain on day 7 of pain diary:



Does your pain radiate to other regions of your body?

- ○ Yes
- ○ No

(If yes, please draw an "↗" the direction in which the pain radiates on diagrams above.)

Scoring method: Yes = 2 points, No = 0 points

Section 4 - Pain Diagram Total:

continued over . . . .

Section 5 - Present Pain

(to be completed dat of appointment)

	Never - 0	1	2	3	4	Always - 5
5.1 During the past 4 weeks, how strong was the strongest pain?	○	○	○	○	○	○
5.2 On average during the past 4 weeks, how strong was the pain?	○	○	○	○	○	○
5.3 How would you rate your pain at this very moment?	○	○	○	○	○	○

	x 0	x 1	x 2	x 3	x 4	x 5
	= 0	=	=	=	=	=

Section 5 - Present Pain Total: _____

Screening Results

Transfer the totals from the various sections:

Section 1 - Symptom Severity

General Total	
Sensations Total	
Fatigue Total	
Thought Processes Total	
Section 2 - Course of Pain Total	
Section 3 - Mobility Total	
Section 4 - Pain Diagram Total	
Section 5 - Present Pain Total	

Section 4 - Pain Trends

One week pain diary Daily average:

Temperature am (°C)	
Pain am (0 - 10)	
Hours slept (hours)	
Temperature pm (°C)	
Pain pm (0 - 10)	
Energy (0 - 10)	

Patient Comments:

This method of scoring of pain and neuropathic pain components has been adapted from painDETECT Pain Questionnaire: Freynhagen R, Baron R, Gockel U, Tölle TR. Curr Med Res Opin. 2006;22:1911-20 and Carruthers GM, Jain AK, De Meirleir K, et al. Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: Clinical Working Case Definition, Diagnostic and Treatment Protocols—A Consensus Document. J Chronic Fatigue Syndr. 2033;11;7-116. Questions from the Hakim AJ, Grahame R. A simple questionnaire to detect hypermobility: an adjunct to the assessment of patients with diffuse musculoskeletal pain. Int J Clin Pract. 2003; 57:163 –6 have also been used.

continued over . . . .

Pain and Fatigue Screening - Clinical Notes

For Doctors Use Only

Transcribe the patient details from the completed Pain and Fatigue Screening questionnaire:

Today's date (dd/mm/yyyy)

Date patient completed questionnaire (dd/mm/yyyy)

Patient Title

First Name

Surname

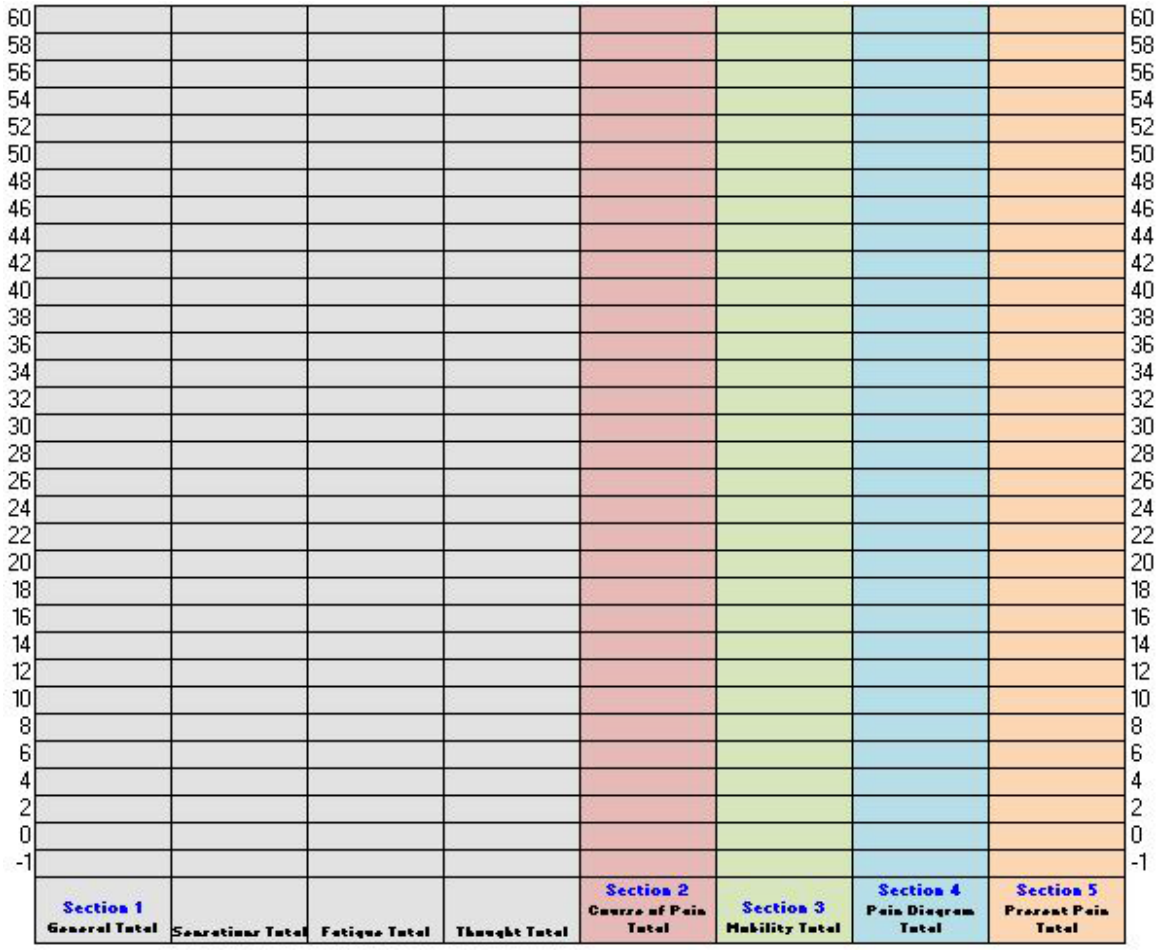
○ Mr
○ Mrs
○ Miss
○ Ms

Sex

Date of birth (dd/mm/yyy)

○ F
○ M

Plot the patient's Screening Results onto the graph below by drawing a dot in the appropriate column and using the number scale:



Sample line: symptoms scoring below the same line are ambiguous, however a pain component can be present.
This pain questionnaire does not replace medical diagnostics.

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