INSTRUCTIONS FOR USE

This tool was designed to standardize a comprehensive psychosocial pain assessment for an interdisciplinary pain service. Through the use of a guided interview process, the clinician explores the impact of unrelieved pain on the patient/family experience in the following five domains: Economic, Social Support, Activities of Daily Living, Emotional Impact, and Coping Style.

Page 1 is designed to provide a synopsis of the patient/family situation for clinical reference and for presentation at an interdisciplinary pain meeting. It includes the interviewer’s impressions, interventions and recommendations as well as a summary of the key domains and associated level of concern.

Pages 2-7 contain questions regarding the five domains listed above. Following the questions in each domain is the opportunity for the patient and family (significant other) to rate their individual level of concern via a 0-10 rating scale (0 = no concern; 10 = greatest concern). Based upon his/her interpretation of the interview, the interviewer rates his/her subjective impressions of the patient’s level of concern. If a family member or significant other is present, his/her rating is then asked and finally the patient’s rating is obtained. Coherence and discrepancies in ratings between the interviewer, patient and family are noted and may then be explored for clinical significance.

Additionally, the assessment of prior history (including traumas such as physical and sexual abuse or unresolved losses) helps a clinician to focus interventions that respect past difficulties as well as past strengths and coping skills that may be transferable to the current pain experience.

This assessment tool is available in English and in two Spanish versions (children/adolescents and adults). Contact Shirley Otis-Green, MSW, LCSW (sotis-green@coh.org) with any questions regarding usage.
Psychosocial Pain Assessment Form

Patient: ___________________________ Age: ____ Date: __________________________

Med. Record #: ___________________________ Significant Other: ___________________________

Diagnosis: ___________________________ Primary Physician: ___________________________

Pain Syndrome: ______________________________________________________________________

Duration of Pain: ___________________________ Assessed by: _______________________________

Please circle appropriate descriptors.

1. **Build:**
   - Cachectic
   - Thin
   - Medium
   - Heavy
   - Obese

2. **Attire:**
   - Disheveled
   - Hospitalized
   - Casual
   - Professional

3. **Eye Contact:**
   - Avoided
   - Appropriate
   - Stared

4. **Attention:**
   - Distracted
   - ________________
   - Hypervigilant
   - ________________
   - Focused

5. **Manner:**
   - Flat
   - Depressed
   - Distant
   - Cooperation
   - Engaged
   - Humorous
   - Dramatic
   - Agitated
   - Anxious
   - Tearful
   - Sobbing
   - Defensive
   - Sarcastic
   - Argumentative
   - Angry
   - Hostile
   - ________________
   - ________________
   - ________________

6. **Verbal Expression:**
   - Terse
   - Vague
   - Average
   - Articulate
   - ________________
   - ________________
   - ________________

7. **Reasoning Ability:**
   - Impaired
   - Age-Appropriate
   - Advanced

8. **Overall Perspective:**
   - Pessimistic
   - ________________
   - Optimistic
   - ________________
   - Unrealistic
   - ________________
   - Realistic
   - ________________

9. **Impressions:**
   - _______________________________________________________________________________
   - _______________________________________________________________________________
   - _______________________________________________________________________________

10. **Interventions:**
    - _______________________________________________________________________________
    - _______________________________________________________________________________
    - _______________________________________________________________________________

11. **Recommendations:**
    - _______________________________________________________________________________
    - _______________________________________________________________________________
    - _______________________________________________________________________________

**Rating (0-10)**

(0 = no concern, 10 = greatest concern)

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Introduction

We recognize that people are often concerned about the impact of pain on many areas of their lives. Unrelieved pain can cause economic, emotional, spiritual and social problems in addition to medical and physical ones. We will be looking at the overall impact of pain in your life and asking several questions to help the Pain Team better understand your personal concerns. The first area we will be addressing is the economic impact of your pain.

Economic

1. How are you supporting yourself financially?

   Work____________________ Family____________________ Disability _________________
   Partner_______________ Retirement/Pensions _______________ Other _________________
   Friends_______________ Savings _____________________

2. Some people we see are concerned about meeting their economic needs. Which of these are worrisome to you?

   None ______
   Housing ______________ Clothing _______________ Prescriptions _______________
   Food ______________ Childcare _______________ Insurance _________________
   Transportation ___________ Medical bills _______________ Other _________________

3. How has your economic situation changed? **Better** ______________ **Worse** ______________

   Describe:
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

4. How upsetting have these changes been to you?

   Describe:
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

5. What would be different in your life if you could afford to change it?

   Describe:
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

6. Please rate your overall level of concern regarding these economic issues.

   **Rating (0-10)**
   (0 = no concern, 10 = greatest concern)

   Economic
   Interviewer Patient Significant Other
   __________ __________ _______________
Social Support
We believe that pain affects not just you, but your entire family. We'd like to look at ways in which you've noticed this impact.

1. Who do you turn to when you're uncomfortable or in pain?
   Self ___________________ Others ___________________ God ___________________________
   Name: ___________________ Relationship: ___________________
   How accessible is this person to you? ___________________
   How helpful is this to you? __________________________

2. How comfortable are you sharing your feelings/fears with your loved ones?
   What makes this difficult for you?
   Describe:
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

3. How satisfied are you with communication with your doctor/medical team?
   Describe:
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

4. Losing people who are important to us affects us deeply. Have you suffered any recent losses?
   Yes ___ No ___
   Describe:
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   Breaking up___________ Separation _____________ Divorce ______________
   Death ________________ Moving away___________ Other ________________

5. Please rate your overall level of concern regarding these social support issues.
   Rating (0-10) (0 = no concern, 10 = greatest concern)
   Interviewer ___________ Patient ___________ Significant Other ___________
Activities of Daily Living

Physical Impact

Often unrelieved pain affects a person's daily routine. How has your pain impacted you in these activities of daily living?

1. Affecting your sleeping patterns? Yes ____ No ____
   - Frequent napping _____
   - Nightmares _____
   - Drowsiness _____
   - Chronic Fatigue _____
   - Difficulty going to sleep _____
   - Difficulty staying asleep _____
   - Difficulty waking up _____
   - Other _____

2. Affecting your eating habits? Yes ____ No ____
   - Weight loss/gain _____
   - Loss of appetite _____
   - Nausea/vomiting _____
   - Changes in taste _____
   - Special Diet _____
   - Feeding Tube _____
   - Difficulty swallowing _____
   - Other _____

3. Affecting your hygiene/elimination habits? Yes ____ No ____
   - Diarrhea _____
   - Catheter _____
   - Difficulty Grooming _____
   - Difficulty Bathing _____
   - Constipation _____
   - Ostomy _____
   - Incontinence _____
   - Other _____

4. Affecting your ability to move? Yes ____ No ____
   - Generalized weakness _____
   - Bed bound _____
   - Crutches/walker/cane _____
   - Getting in/out of car _____
   - Lifting/carrying _____
   - Limited range of motion _____
   - Wheel chair _____
   - Walking/standing _____
   - Climbing stairs _____
   - Other _____
   - No longer athletic _____
   - S.O.B. _____

5. Affecting your roles in your family? Yes ____ No ____
   In what ways?
   ________________________________________________________________

6. Affecting your sexual functioning? Yes ____ No ____
   In what ways?
   ________________________________________________________________

7. Affecting your physical appearance? Yes ____ No ____
   In what ways?
   ________________________________________________________________

8. How has your energy level changed? Less ______ Same _______ Improved ______

9. Please rate your overall level of concern regarding these physical changes.
   Rating (0-10) (0 = no concern, 10 = greatest concern)
   ____________________ ____________________ ____________________
**Emotional**

Pain affects our emotions. These questions will help us better understand your pain's impact upon you emotionally.

1. Have you been troubled by feelings of:
   - Depression **Yes** __No__ Describe: ____________________________________________
   - Frustration/Anger **Yes** __No__ Describe: ____________________________________________
   - Anxiety **Yes** __No__ Describe: ____________________________________________
   - Panic Attacks **Yes** __No__ Describe: ____________________________________________
   - Mood Swings **Yes** __No__ Describe: ____________________________________________
   - Difficulty Concentrating **Yes** __No__ Describe: ____________________________________________
   - Loss of Motivation **Yes** __No__ Describe: ____________________________________________

2. Do you ever see or hear things that others don't? **Yes** __No__
   *Describe:________________________________________________________________________________
   ____________________________________________________________________________________

3. Are there any medical tests or procedures that frighten you? **Yes** __No__
   *Describe:________________________________________________________________________________
   ____________________________________________________________________________________

4. Have you ever thought about hurting yourself or taking your life? **Yes** __No__
   *Describe:________________________________________________________________________________
   ____________________________________________________________________________________

5. Please rate your overall level of concern regarding these emotional issues.
   **Rating (0-10)** (0 = no concern, 10 = greatest concern)
   
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Coping

People handle pain and distress in many ways. These questions will help us to better understand how you cope with upsetting situations.

1. Sometimes, doing things we enjoy distracts us from our pain. What activities are you able to do that you enjoy?
   - None _____
   - Family _____
   - Friends _____
   - Hobbies _____
   - Reading _____
   - Religion _____
   - Gardening _____
   - Traveling _____
   - Exercise _____
   - Art/Music _____
   - TV _____
   - Pets _____
   - Other: _______

2. Some people find comfort in spirituality to help them cope with difficult situations. What role does spirituality have in helping you?
   - Describe:

3. Many people in your situation ask "Why did this happen to me?" How have you attempted to "make sense" of your painful experiences?
   - Describe:

4. Past stressful events can impact us in the present. What kinds of stress have you had to handle before? Describe:

   - Child abuse? Yes ___ No ___ Describe:
   - Sexual abuse? Yes ___ No ___ Describe:
   - Family violence? Yes ___ No ___ Describe:

5. Some people find that counseling sessions or attending support groups can help them cope with stressful situations.
   - Have you ever been in counseling? Yes ___ No ___ What was the focus of your therapy?___________
   - Have you ever attended a support group? Yes ___ No ___ What kind? __________________________
   - How helpful was this?

6. Some people are prescribed medications to help them cope. Which of these have you been prescribed?
   - None _____
   - Other: ___________________________________________________________________________
   - Anti-Anxiety medications? Yes ___ No ___ Describe:
   - Anti-Depressant medications? Yes ___ No ___ Describe:
   - Pain Medications? Yes ___ No ___ Describe:
   - Do you ever take your prescriptions differently than ordered? Yes ___ No___
   - Describe: ____________________________________________
Coping continued

7. Some people use other chemicals to help them cope. Which of these do you use?

   Tobacco? Yes ___ No ___ Describe:___________________________________________
   Alcohol? Yes ___ No ___ Describe:___________________________________________
   Recreational Drugs? Yes ___ No ___ Describe:_________________________________

   Have you ever tried to stop using these? Yes ___ No ___ Describe:________________
   Do you worry about your usage of these? Yes ___ No ___ Describe:________________
   Has your family worried about your usage of these? Yes ___ No ___ Describe:________

8. What changes do you expect in your future?

   Describe:____________________________________________________________________

9. Overall, how satisfied are you with your present quality of life?

   Describe:____________________________________________________________________

10. Please rate your overall level of concern regarding your ability to cope or manage your pain.

    Rating (0-10) (0 = no concern, 10 = greatest concern)

    Interviewer Patient Significant Other

    Coping __________ _______ ______________

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City of Hope National Medical Center

Publications
Otis-Green, S. (2006). Psychosocial Pain Assessment Form. In Dow (Ed.), Nursing Care of


The Psychosocial Pain Assessment Form can be found on the
City of Hope Pain/Palliative Resource Center website at
http://www.cityofhope.org/prc/pain_assessment.asp (English)
http://www.cityofhope.org/prc/pdf/Forma%20%20Adultos%20PS.pdf (Spanish - Adults)
http://www.cityofhope.org/prc/pdf/Formulario%20Ninos.pdf (Spanish - Children/Adolescents)