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 domains: Economic, Social Support, Activities of Daily Living, Emotional Impact, and Coping Style.

Page 2 is designed to provide a synopsis of the patient/family situation. It is designed to be completed following the guided interview as a summary for clinical reference and to aid in a brief presentation for 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 3-8 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 their interpretation of the interview, the interviewer rates their subjective impressions of the patient’s level of concern. If a family member or significant other is present, their rating is then asked and finally the patients rating. Coherence and discrepancies in ratings amongst the interviewer, patient and family are noted and may 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, 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
     - -----------------------------------------------------------
   - Focused

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

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

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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<th>Patient</th>
<th>Significant Other</th>
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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)
   
<table>
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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
   Social Support __________ __________ __________
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 _____
   - Limited range of motion _____
   - Bed bound _____
   - Wheel chair _____
   - Crutches/walker/cane _____
   - Walking/standing _____
   - Getting in/out of car _____
   - Climbing stairs _____
   - Lifting/carrying _____
   - 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)

   Activities of daily living        Interviewer        Patient        Significant Other
**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)

   **Emotional issues**

   Interviewer   Patient   Significant Other
   
   __________________   __________________   __________________
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       __________  _______  ______________

Developed by: Shirley-Otis-Green, MSW, LCSW
City of Hope National Medical Center

Publications


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)