# PAIN QUESTIONNAIRE FOR CHILDREN AND ADOLESCENTS

## ADOLESCENT VERSION

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Pain Questionnaire for Children and Adolescents
Adolescent Version - Initial, Version 3.0



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German
Paediatric Pain Centre

Vestische Kinder- und
Jugendklinik Datteln
Universität Witten/Herdecke

Hi,

This questionnaire should help us get an extensive overview of your pain condition. All information being gathered from this and further questionnaires as well as information gained in the talks will be treated as strictly confidential.
You might consider some questions of no importance since they do not appear to be linked to your pain. However, pain is a very complex condition, so that even seemingly unimportant details are of importance to us.

If you have any questions, just ask us.

## GENERAL INFORMATION ON YOU AND YOUR FAMILY

1. DATE:

2. YOUR NAME:

3. YOUR AGE: 4. YOUR DATE OF BIRTH:

5. WHICH SCHOOL DO YOU ATTEND? (EXAMPLE: SECONDARY SCHOOL)?

6. WHAT GRADE?

7. IN WHICH COUNTRY WERE YOUR PARENTS BORN?

**MOTHER** .....

**FATHER** .....

8. SINCE WHEN DO YOU LIVE IN THIS COUNTRY?

◯ since my birth ◯ since I am ..... years old ◯ I don't know

9. WHICH LANGUAGES DO YOU SPEAK AT HOME?

◯ English ◯ other languages: .....

# MEDICAL HISTORY

## GENERAL MEDICAL INFORMATION

10. PLEASE WRITE DOWN WHICH **SEVERE AND LONG LASTING DISEASES OR PAIN CONDITIONS** OTHER FAMILY MEMBERS OR FRIENDS ARE CURRENTLY EXPERIENCING OR HAVE EXPERIENCED IN THE PAST.

| WHO? | WHEN? | KIND OF DISEASE OR PAIN PROBLEM? | DISEASE OUTCOME? |
|---|---|---|---|
| *Example: Brother* | *since 2002* | *Rheumatism, joints* | *Still present* |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

11. DID YOU TAKE ANY PAIN MEDICATION IN **THE PAST 3 MONTHS**?

○ yes ○ no

If so, please enter the following information:

| DRUG | DOSE RATE AND APPLICATION (tablet, drops suppository, puffs) | HOW OFTEN PER DAY? AS REQUIRED? | ON HOW MANY DAYS PER MONTH? | HOW EFFECTIVE? 1 = not effective 2 = little effective 3 = very effective |
|---|---|---|---|---|
| *Example: Ibuprofen* | *300 mg oral solution* | *1x* | *3 days a month* | *3* |
| | | | | |
| | | | | |
| | | | | |

# INFORMATION ON YOUR PAIN

## YOUR PAIN HISTORY – HOW DID IT START?

12. WHEN DID YOUR **CURRENT PAIN PROBLEM** START?

.....

.....

13. DID THE PAIN VARY IN INTENSITY?

○ yes ○ no

If so, how did the pain vary in intensity (e.g. increased, decreased, remained the same, permanently alternating, sometimes it is completely absent)?

.....

.....

14. AT THE TIME WHEN THE PAIN STARTED, DID ANYTHING SPECIAL HAPPEN IN YOUR LIFE?

○ yes ○ no

If so, what was special (e.g.: my best friend moved away; I attended a new school; I was ill; we moved; my parents got a divorce; I won a swimming competition;...)?

.....

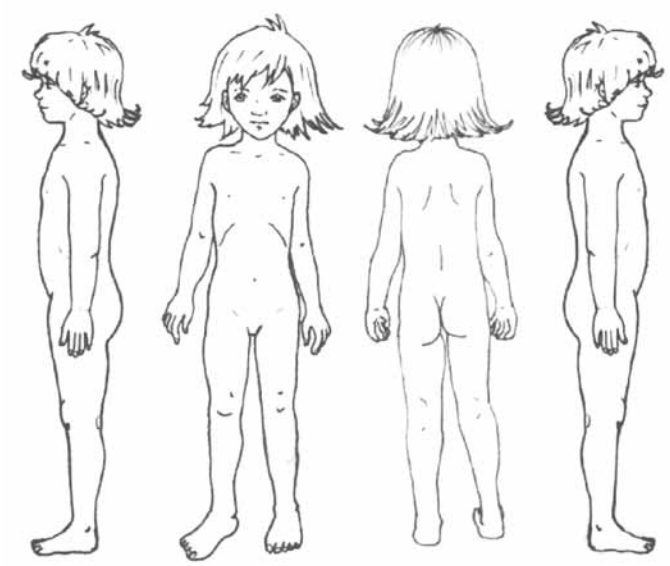
.....

## YOUR PAIN – NOW

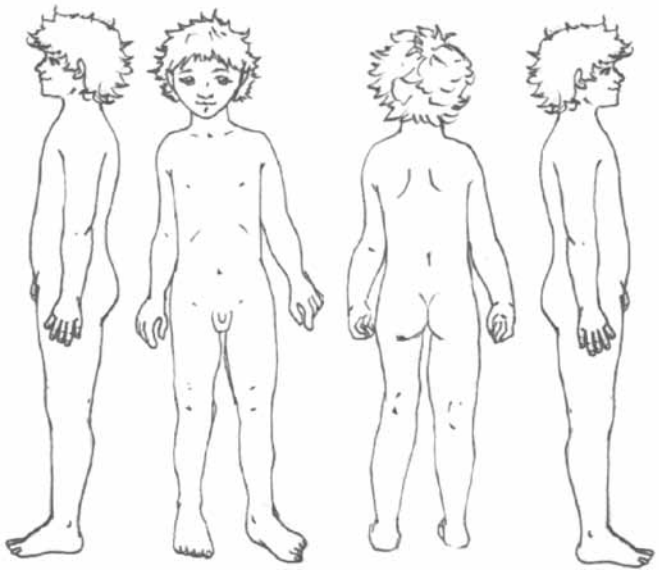
15. PLEASE MARK („X“) THE AREA(S) THAT ARE PAINFUL.

16. PLEASE ALSO MARK THE AREA WITH THE STRONGEST PAIN WITH A CIRCLE (“○”) **(MAIN PAIN LOCATION)**.

GIRLS



BOYS



17. WHAT IS THE WORST TIME OF THE DAY?

18. WHAT IS THE BEST TIME OF THE DAY?

19. ON WHICH WEEKDAY DO YOU HAVE THE MOST PAIN?

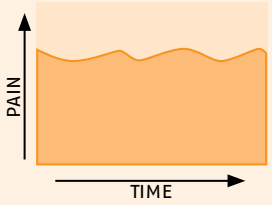
20. AT WHICH TIME OF THE YEAR OR IN WHICH MONTH DO YOU HAVE THE MOST PAIN?

21. HOW OFTEN DO YOU EXPERIENCE YOUR **MAIN PAIN** (MARKED WITH A „○“)?

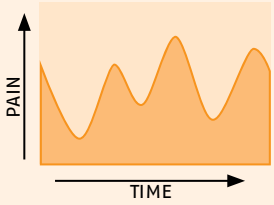
- ○ once a year
- ○ once a month
- ○ once a week
- ○ once a day
- ○ permanently
- ○ several times a year
- ○ several times a month
- ○ several times a wek
- ○ several times a day

22. WHICH PICTURE BEST MATCHES YOUR MAIN PAIN IN THE **PAST 7 DAYS?**

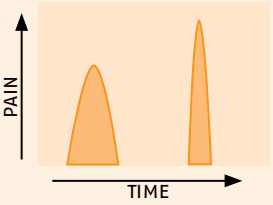
Please read all descriptions carefully and mark the picture that describes your pain best.



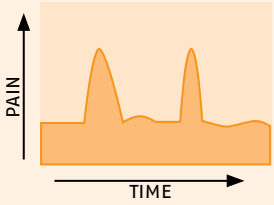

○ My pain is permanently there and never gone. Pain intensity is always similar and varies little.




○ My pain is permanently there and never gone. Pain intensity is always different and varies strongly.




○ My pain is sometimes there and other times gone. There are times without pain.




○ My pain is permanently there and never gone. There are times with very intense pain that occur like additional attacks.

23. DO YOU HAVE **PERMANENT** PAIN (THAT MEANS, THE PAIN IS **ALWAYS THERE** AND **NEVER GONE**)?

◯ no, my pain is sometimes there and sometimes gone

◯ yes, my pain is always there and never gone

IN CASE YOU HAVE **PERMANENT** PAIN: FOR HOW LONG?

◯ for..... days ◯ for ..... weeks ◯ for..... months ◯ for ..... years

24. HOW LONG DOES YOUR **MAIN PAIN** GENERALLY LAST?

◯ minutes — More specifically, about ..... minutes

◯ hours — More specifically, about ..... hours

◯ days — More specifically, about ..... days

◯ permanently

In the following we would like to learn a bit more about your **main pain** (the one you marked with a circle („◯“) in the body diagramm).

You can use the numbers to indicate how strong your pain is: **0** means that you have no pain. Starting with **1** is a light pain, and it is getting stronger with the following numbers up to **10**. **10** means that you have the strongest pain.

PLEASE THINK BACK TO THE **PAST 4 WEEKS** FOR THE FOLLOWING TWO QUESTIONS.

25. HOW STRONG WAS YOUR STRONGEST **MAIN PAIN** IN THE **PAST 4 WEEKS**?

PLEASE MARK THE NUMBER THAT FITS BEST. MARK ONLY **ONE** NUMBER!

0 ..... 1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 ..... 7 ..... 8 ..... 9 ..... 10

no pain — worst pain

26. WHEN YOU WERE EXPERIENCING THE **MAIN PAIN**, HOW STRONG WAS THIS PAIN MOSTLY DURING THE **PAST 4 WEEKS?**

PLEASE MARK THE NUMBER THAT FITS BEST. MARK ONLY **ONE** NUMBER!

0 ..... 1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 ..... 7 ..... 8 ..... 9 ..... 10

no pain — worst pain

PLEASE THINK BACK TO THE **PAST 7 DAYS** FOR THE FOLLOWING TWO QUESTIONS:

27. HOW STRONG WAS YOUR **STRONGEST MAIN PAIN** IN **THE PAST 7 DAYS**?

PLEASE MARK THE NUMBER THAT FITS BEST. MARK ONLY **ONE** NUMBER!

0 ····· 1 ····· 2 ····· 3 ····· 4 ····· 5 ····· 6 ····· 7 ····· 8 ····· 9 ····· 10

no pain — worst pain

28. WHEN YOU WERE EXPERIENCING THE MAIN PAIN, HOW STRONG WAS THIS PAIN **MOSTLY** DURING THE **PAST 7 DAYS**?

PLEASE MARK THE NUMBER THAT FITS BEST. MARK ONLY **ONE** NUMBER!

0 ····· 1 ····· 2 ····· 3 ····· 4 ····· 5 ····· 6 ····· 7 ····· 8 ····· 9 ····· 10

no pain — worst pain

29. DO YOU ALSO HAVE OTHER PHYSICAL TROUBLE WHILE YOU ARE EXPERIENCING PAIN?

◯ yes ◯ no

WHEN I AM IN PAIN,

◯ I feel nauseous
◯ bright light bothers me
◯ loud sounds bother me
◯ my skin turns red or white
◯ I am very tired and exhausted
◯ I have a weird feeling in my hands
◯ I have problems concentrating
◯ I have to throw up
◯ I have flickering in front of my eyes
◯ I feel dizzy
◯ the painful area becomes swollen
◯ I have to use the toilet
◯ I feel strange
◯ things smell or taste different than usual

Or what else?

.....

.....

.....

.....

.....

30. DO YOU NOTICE WHEN YOUR PAIN IS COMING?

◯ yes ◯ no

If so, how do you notice that the pain is going to start soon (Example: I am tired; I have horrible thoughts; I am in a bad mood; I feel weak; I cannot concentrate; ...)?

.....

.....

.....

.....

31. WITH THE FOLLOWING LIST OF WORDS YOU CAN DESCRIBE IN DETAIL **HOW YOU EXPERIENCE YOUR PAIN**. PLEASE DO NOT SKIP ONE OF THE DESCRIPTIONS AND **MARK EACH ROW WITH A CROSS** INDICATING HOW MUCH EACH STATEMENT APPLIES TO YOU.

| **I EXPERIENCE MY PAIN AS ...** | | | | |
|---|---|---|---|---|
| | **Fully applies** | **Mostly applies** | **Applies somewhat** | **Does not apply** |
| cruel | ◯ | ◯ | ◯ | ◯ |
| killing | ◯ | ◯ | ◯ | ◯ |
| miserable | ◯ | ◯ | ◯ | ◯ |
| dreadful | ◯ | ◯ | ◯ | ◯ |
| horrible | ◯ | ◯ | ◯ | ◯ |
| tormenting | ◯ | ◯ | ◯ | ◯ |
| terrible | ◯ | ◯ | ◯ | ◯ |
| unbearable | ◯ | ◯ | ◯ | ◯ |
| burning | ◯ | ◯ | ◯ | ◯ |
| beating | ◯ | ◯ | ◯ | ◯ |
| stabbing | ◯ | ◯ | ◯ | ◯ |
| throbbing | ◯ | ◯ | ◯ | ◯ |
| pressing | ◯ | ◯ | ◯ | ◯ |
| pulsating | ◯ | ◯ | ◯ | ◯ |

# FACTORS INFLUENCING THE PAIN

## 32. WHAT EASES AND WHAT EXACERBATES YOUR PAIN?

| SITUATION | EASING | NO INFLUENCE | INCREASING |
|---|---|---|---|
| Physical activity (running, cycling, etc.) | ○ | ○ | ○ |
| Mental stress (test, argument, etc.) | ○ | ○ | ○ |
| Inappropriate posture (slouching, long standing) | ○ | ○ | ○ |
| Frequent changing of position, walking around | ○ | ○ | ○ |
| Relaxing, lying down, resting | ○ | ○ | ○ |
| Other situations ..... | ○ | ○ | ○ |

| | I AGREE | I DO NOT AGREE |
|---|---|---|
| My pain cannot be influenced by anything. | ○ | ○ |

## 33. DOES YOUR PAIN GET WORSE WHEN YOU ARE ...

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| tired | ○ | ○ | angry | ○ | ○ |
| tense | ○ | ○ | busy | ○ | ○ |
| bored | ○ | ○ | lonely | ○ | ○ |
| happy | ○ | ○ | mischievous | ○ | ○ |
| unhappy | ○ | ○ | excited | ○ | ○ |

## 34. DOES ANYTHING TRIGGER YOUR PAIN?

○ yes ○ no

If so, what triggers your pain (e.g. not sleeping enough, being nervous before an exam, heat, cold, physical activity when doing sports, change in weather, light, noise, trouble, arguments, sitting in front of the computer to play or work, TV, hectic activity, problems in school, weekend or start of holidays, ...)?

.....

.....

.....

.....

# HANDLING THE PAIN

35. WHAT DO YOU DO WHEN YOU ARE IN PAIN?

36. WHAT DO YOUR PARENTS DO WHEN YOU ARE IN PAIN?

# YOUR EXPECTATIONS

37. WHAT WOULD BE DIFFERENT IF YOUR PAIN SUDDENLY DISAPPEARED?

# IMPLICATIONS OF THE PAIN FOR YOU AND YOUR DAILY LIFE

38. WHEN YOU WERE IN PAIN, HOW OFTEN DURING THE **PAST 4 WEEKS** DID IT IMPAIR YOU IN THE FOLLOWING ACTIVITIES? PLEASE CIRCLE THE MOST APPROPRIATE NUMBER

| | NEVER | SELDOM | SOMETIMES | OFTEN | ALWAYS |
|---|---|---|---|---|---|
| Enjoying family life | 1 | 2 | 3 | 4 | 5 |
| Eating/appetite | 1 | 2 | 3 | 4 | 5 |
| Meeting friends | 1 | 2 | 3 | 4 | 5 |
| Sports | 1 | 2 | 3 | 4 | 5 |
| Sleeping | 1 | 2 | 3 | 4 | 5 |
| Watching T.V. | 1 | 2 | 3 | 4 | 5 |
| Reading | 1 | 2 | 3 | 4 | 5 |
| Homework (or: painting, handicraft) | 1 | 2 | 3 | 4 | 5 |
| School attendance | 1 | 2 | 3 | 4 | 5 |
| Going to the cinema (or: playground) | 1 | 2 | 3 | 4 | 5 |
| Favourite activity | 1 | 2 | 3 | 4 | 5 |
| Disliked activities | 1 | 2 | 3 | 4 | 5 |

Can you think of something else where your pain impairs you? Or would you like to describe one topic with some more detail? You can write it down here:

.....

.....

.....

39. DID YOUR PAIN KEEP YOU FROM DOING THINGS YOU WANTED TO DO DURING THE **PAST 3 MONTHS** (E.G. GO ON HOLIDAY, HORSEBACK RIDING)?

◯ yes ◯ no

If so, what was it?

.....

.....

.....

40. DID THE PAIN KEEP YOU FROM ATTENDING SCHOOL DURING THE **PAST 3 MONTHS**?

◯ no ◯ yes, on ..... days I did not attend school.

41. DID THE PAIN CAUSE YOU TO LEAVE CLASS EARLY OR ATTEND CLASS LATE DURING **THE PAST 3 MONTHS**?

◯ no ◯ yes, on ..... days I left class early / started late.

42. DURING THE **PAST 7 DAYS**, DID THE PAIN KEEP YOU FROM PERFORMING **EXHAUSTING** PHYSICAL EXERCISE, SUCH AS RUNNING, CYCLING, LIFTING HEAVY THINGS, OR PLAYING EXHAUSTING SPORTS?

◯ no ◯ yes, on ..... days.

43. DURING THE **PAST 7 DAYS,** DID THE PAIN KEEP YOU FROM PERFORMING **MODERATE** PHYSICAL EXERCISE, SUCH AS CLIMBING SEVERAL FLIGHTS OF STAIRS, BENDING DOWN, FAST WALKING, OR LIFTING?

◯ no ◯ yes, on ..... days.

44. DURING THE **PAST 7 DAYS**, DID THE PAIN KEEP YOU FROM PERFORMING **LIGHT** PHYSICAL EXERCISE, SUCH AS WALKING, SITTING OR STANDING?

◯ no ◯ yes, on ..... days.

IS THERE ANYTHING ELSE YOU WISH TO TELL US – CONCERNING YOU OR YOUR PAIN, OR THINGS THAT YOU CONSIDER **IMPORTANT**? YOU CAN WRITE IT ALL DOWN HERE.

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## THANK YOU!

German
Paediatric Pain Centre

Vestische Kinder- und
Jugendklinik Datteln
Universität Witten/Herdecke

universität
Witten/Herdecke

TRÄGER:
VESTISCHE CARITAS-KLINIKEN GMBH