



**PAIN QUESTIONNAIRE
FOR CHILDREN AND
ADOLESCENTS**



PARENT VERSION

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Pain Questionnaire for Children and Adolescents
Parent Version – Follow-up, Version 3.0

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Layout: RDN Agentur für PR, Recklinghausen



Dear parents,

This questionnaire should help us find out how your child has been since our last appointment. Please contact us if you have any questions.

Your Pain Management Team

GENERAL INFORMATION ON THE CHILD AND THE FAMILY INFORMATION ON PARENTS

1. DATE:

2. The questionnaire is filled out by:

mother

father

other:

Information on the child

3. NAME:

4. AGE:

5. DATE OF BIRTH:

YOUR CHILD'S PAIN THERAPY

6. IN YOUR OPINION, HAS YOUR CHILD'S PAIN PROBLEM CHANGED SINCE OUR LAST APPOINTMENT?

a) My child...

- has experienced pain in the last month
- has not experienced pain for more than 1 month

If so, for how long has he/she not had pain anymore?

If he/she does **not have pain anymore**, you only need to fill out some of the following questions.

- for 1-2 months please answer questions 7 to 13
- for 2-3 months please answer questions 7 to 13
- more than 3 months please answer question 7

If your child still has pain, please answer all questions.

b) Compared to our last appointment, my child is experiencing pain...

- much less frequently a bit less frequently
- as frequently as during our last appointment
- a bit more frequently much more frequently

c) Compared to our last appointment, my child's pain is...

- much less a bit less
- as intense as during our last appointment
- a bit more much more

7. HOW SATISFIED ARE YOU WITH YOUR CHILD'S PAIN TREATMENT? PLEASE DO NOT ONLY CONSIDER THE PAIN RELIEF BUT ALSO FURTHER SYMPTOMS, POSSIBLE SIDE EFFECTS, YOUR CHILD'S PHYSICAL AND EMOTIONAL STATE AND HOW WELL YOUR CHILD FUNCTIONS IN THE FAMILY AND IN SCHOOL.

Please describe how satisfied you are by means of the numbers.

0 means that you are very unsatisfied. **10** means that you are very satisfied with your child's pain treatment.

PLEASE MARK THE APPROPRIATE NUMBER. MARK ONLY **ONE** NUMBER!

0 1 2 3 4 5 6 7 8 9 10

very
unsatisfied

very
satisfied

PLEASE SPECIFY THE REASONS FOR THIS SATISFACTION RATING:

.....

.....

.....

.....

.....

YOUR CHILD'S PAIN IN THE PAST 3 MONTHS

8. HOW OFTEN DID YOU HAVE A DOCTOR/THERAPIST APPOINTMENT DUE TO YOUR CHILD'S PAIN IN **THE PAST 3 MONTHS?**

never

about appointments during the past 3 months

9. DID YOUR CHILD TAKE ANY PAIN MEDICATION IN THE PAST 3 MONTHS?

yes no

If so, please enter the following information

DRUG	DOSE RATE AND APPLICATION (tablets, drops, suppository, puffs)	HOW OFTEN PER DAY? AS REQUIRED?	HOW OFTEN PER MONTH?	HOW EFFECTIVE? 1 = not effective 2 = less effective 3 = very effective
<i>Example: Ibuprofen</i>	<i>300 mg oral solution</i>	<i>1x</i>	<i>3 days a month</i>	<i>3</i>

10. DID YOUR CHILD RECEIVE ANY ADDITIONAL TREATMENT IN THE PAST 3 MONTHS IN ORDER TO RELIEVE THE PAIN (E.G. RELAXATION TECHNIQUES, ACUPUNCTURE, ELECTRIC NERVE STIMULATION (TENS), PHYSIOTHERAPY, MASSAGES, PSYCHOTHERAPY, INJECTIONS, NERVE BLOCKS, CURE / REHABILITATION, OPERATIONS)?

yes no

If so, which one(s):

TIME PERIOD	TREATMENT	HOW EFFECTIVE? 1 = not effective 2 = less effective 3 = very effective
<i>Example: February till October 2008</i>	<i>Learning a relaxation technique</i>	<i>3</i>

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

yes no

If so, please explain:

.....

.....

.....

12. DID THE PAIN KEEP YOUR CHILD FROM **ATTENDING SCHOOL (OR DAY CARE)** DURING THE **PAST 3 MONTHS**?

no yes, on days my child did not attend school (day care).

13. DID THE PAIN CAUSE YOUR CHILD TO LEAVE CLASS EARLY OR ATTEND CLASS/DAY CARE LATE DURING THE **PAST 3 MONTHS**?

no yes, on days my child left class early / started late.

If your child has **no pain any more**, you need not to answer the following questions!

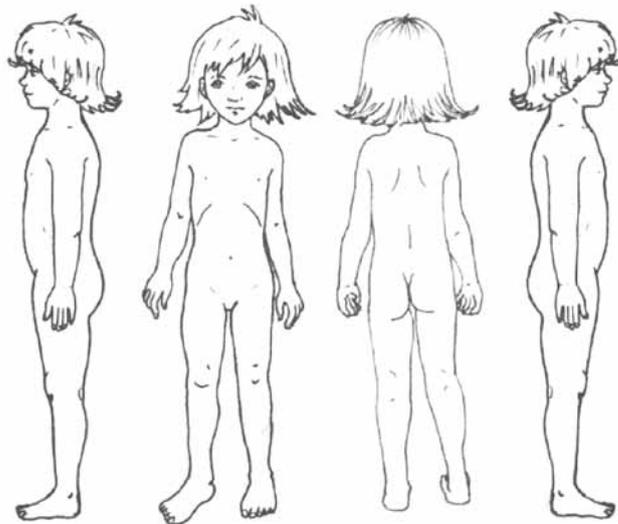
YOUR CHILD'S PAIN CHARACTERISTICS

CURRENT PAIN

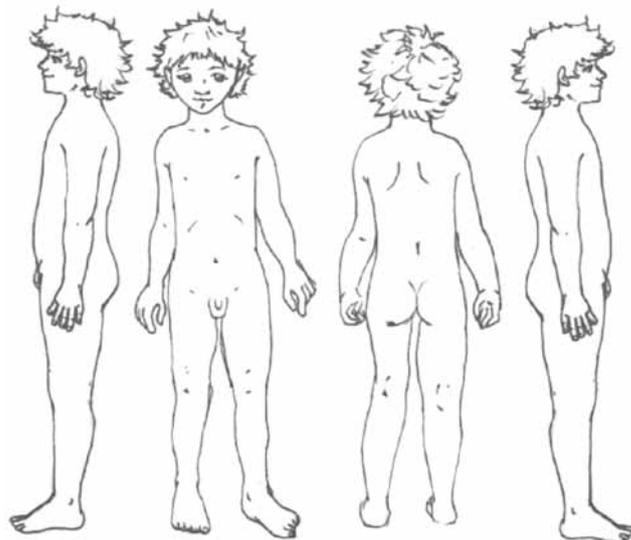
14. PLEASE MARK („X“) YOUR CHILD'S PAIN AREA(S).

15. PLEASE ALSO MARK THE AREA WITH THE STRONGEST PAIN WITH A CIRCLE („○“) (MAIN PAIN LOCATION).

GIRLS



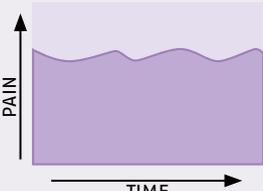
BOYS



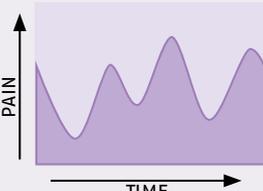
16. HOW OFTEN DOES YOUR CHILD'S **MAIN PAIN** (MARKED WITH A „○“) OCCUR?

- | | | |
|------------------------------------|---|-----------------------------------|
| <input type="radio"/> once a year | <input type="radio"/> several times a year | |
| <input type="radio"/> once a month | <input type="radio"/> several times a month | |
| <input type="radio"/> once a week | <input type="radio"/> several times a week | |
| <input type="radio"/> once a day | <input type="radio"/> several times a day | <input type="radio"/> permanently |

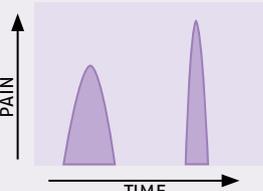
17. WHICH PICTURE BEST MATCHES YOUR CHILD'S MAIN PAIN IN THE PAST 7 DAYS?



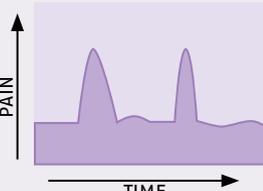
My child has permanent pain. Pain intensity varies little.



My child has permanent pain. Pain intensity varies strongly.



My child's pain always returns, i.e. they appear sporadic or in attacks. There are also times without pain.



My child has permanent pain. Occasionally, there are additional, stronger pain attacks.

18. HOW LONG DOES YOUR CHILD'S 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 child's main pain (the one you marked with a circle („○“) in the body diagram).

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

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

19. HOW STRONG DO YOU THINK YOUR CHILD'S STRONGEST PAIN WAS IN THE PAST 4 WEEKS?

PLEASE MARK THE APPROPRIATE NUMBER. MARK ONLY **ONE** NUMBER!

0 1 2 3 4 5 6 7 8 9 10

no pain worst pain

20. WHEN YOUR CHILD WAS EXPERIENCING THE **MAIN PAIN**, HOW STRONG, DO YOU THINK, WAS THIS PAIN **MOSTLY** WITHIN THE **PAST 4 WEEKS**?

PLEASE MARK THE APPROPRIATE NUMBER. MARK ONLY **ONE** NUMBER!

0 1 2 3 4 5 6 7 8 9 10

no
pain

worst
pain

21. DID YOUR CHILD HAVE **PERMANENT PAIN** DURING THE **PAST 4 WEEKS** (I.E. THE PAIN WAS **ALWAYS THERE** AND **NEVER GONE**)?

- yes, my child's pain was always there and never gone
- no, the pain was sometimes there and sometimes gone

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

22. HOW STRONG DO YOU THINK YOUR CHILD'S **STRONGEST MAIN PAIN** WAS IN THE **PAST 7 DAYS**?

PLEASE MARK THE APPROPRIATE NUMBER. MARK ONLY **ONE** NUMBER!

0 1 2 3 4 5 6 7 8 9 10

no
pain

worst
pain

23. WHEN YOUR CHILD WAS EXPERIENCING THE **MAIN PAIN**, HOW STRONG, DO YOU THINK, WAS THIS PAIN **MOSTLY** WITHIN THE **PAST 7 DAYS**?

PLEASE MARK THE APPROPRIATE NUMBER. MARK ONLY **ONE** NUMBER!

0 1 2 3 4 5 6 7 8 9 10

no
pain

worst
pain

24. DID YOUR CHILD HAVE **PERMANENT PAIN** DURING THE **PAST 7 DAYS** (I.E. THE PAIN WAS **ALWAYS THERE** AND **NEVER GONE**)?

- yes, my child's pain was always there and never gone.
- no, the pain was sometimes there and sometimes gone.

25. YOU CAN DESCRIBE YOUR CHILD'S PAIN MORE CLEARLY WITH THE FOLLOWING LIST OF WORDS. PLEASE DO NOT SKIP ANY OF THE DESCRIPTIONS, AND **MARK EACH ROW WITH A CROSS** INDICATING HOW MUCH EACH STATEMENT APPLIES TO YOUR CHILD.

IN MY OPINION, MY CHILD'S PAIN IS ...				
	fully applies	mostly applies	applies somewhat	does not apply
cruel	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
killing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
miserable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
dreadful	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
horrible	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
tormenting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
terrible	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
unbearable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
burning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
beating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
stabbing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
throbbing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
pressing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
pulsating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

HANDLING THE PAIN

26. WHAT DOES YOUR CHILD DO WHEN HE/SHE IS IN PAIN?

.....

.....

.....

27. WHAT DO YOU DO WHEN YOUR CHILD IS IN PAIN?

.....

.....

.....

GENERAL AND PHYSICAL IMPAIRMENT DUE TO PAIN

28. WHICH OF THE FOLLOWING ACTIVITIES OF YOUR CHILD WERE IMPAIRED DUE TO PAIN DURING THE PAST 4 WEEKS? PLEASE CIRCLE THE MOST APPROPRIATE NUMBER. (In brackets you find alternative activities for pre-school children):

	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 (or: day care)	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

ARE THERE OTHER SITUATIONS IN WHICH THE PAIN HANDICAPS OR IMPAIRS YOUR CHILD? OR WOULD YOU LIKE TO DESCRIBE ONE TOPIC WITH SOME MORE DETAIL?

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