PAIN QUESTIONNAIRE FOR CHILDREN AND ADOLESCENTS

PARENT VERSION

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Pain Questionnaire for Children and Adolescents
Parent Version – Initial, Version 3.0

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German
Paediatric Pain Centre

Vestische Kinder- und
Jugendklinik Datteln
Universität Witten/Herdecke

Dear Parents,

This questionnaire should help us get an extensive overview of your child's pain condition in order to initiate comprehensive treatment. All information being gathered from this and further questionnaires as well as information gained in the talks will be treated as strictly confidential.

Please answer all questions, even those that appear unimportant to you. Pain is a very complex condition, so that even seemingly unimportant details are of importance to us. If you do not understand a question, please highlight this question with a question mark.

Your data and your child's data are subject to **medical confidentiality**.

It is our goal to further improve the detection, diagnosis and treatment of children with chronic pain. In order to achieve this goal, we rely on information on you and your child. Information will be stored and further analyzed anonymously, i.e. there is no link between information and the actual person.

We kindly ask you for your agreement to store the data on you and your child.

This agreement can be taken back at anytime without giving reasons. In case you do not want to agree to the use of your data, or if you decide to take back the agreement at any given point of time, there will of course be **no disadvantage** to your child's treatment.

Your Pain Management Team

AGREEMENT

First and last name of your child

I AGREE TO STORING AND ANONYMOUSLY USING MY AND MY CHILD'S DATA AS ASSESSED IN THE QUESTIONNAIRES.

- ○ Yes
- ○ No

Place / Time

Signature of both parents**

** In case of special family situations (e.g. parent's divorce, single mother/father), we seek information on the attachment figure living with your child for at least one year.

GENERAL INFORMATION ON THE CHILD AND THE FAMILY

INFORMATION ON PARENTS

1. DATE:

2. YOUR NAME:

3. ADDRESS (STREET, NO):

4. ZIP CODE:

5. PHONE (LANDLINE):

6. PHONE (MOBILE):

6. E-MAIL:

7. THE QUESTIONNAIRE IS FILLED OUT BY:

◯ mother ◯ father ◯ other: .....

8. MOTHER'S JOB: .....

◯ fulltime ◯ part time (%): ..... ◯ not working

Specifics (e.g. shift-work): .....

9. FATHER'S JOB: .....

◯ fulltime ◯ part time (%): ..... ◯ not working

Specifics (e.g. shift-work): .....

10. ETHNICITY?

MOTHER

.....

FATHER

.....

11. WHAT IS YOUR COUNTRY OF ORIGIN?

MOTHER

.....

FATHER

.....

12. SINCE WHEN DO YOU LIVE IN THIS COUNTRY?

MOTHER

◯ since birth ◯ since (date) .....

FATHER

◯ since birth ◯ since (date) .....

13. WHICH LANGUAGES DO YOU SPEAK AT HOME?

◯ English ◯ other languages: .....

14. SINCE WHEN DOES YOUR CHILD LIVE IN THIS COUNTRY?

◯ since his/her birth ◯ since he/she was ..... years old

Information on the child

15. NAME:

16. AGE:

17. DATE OF BIRTH:

18. GENDER: ◯ female ◯ male

19. WHICH FACILITY DOES YOUR CHILD ATTEND?

◯ nursery school ◯ primary school ◯ middle school ◯ secondary school

◯ special school ◯ day care centre ◯ non yet

◯ other: .....

20. WHICH GRADE? .....

INFORMATION ON THE FAMILY

21. PLEASE DESCRIBE THE PARENTAL RELATIONSHIP STATUS.

- ○ living together
- ○ never lived together
- ○ living apart/divorced since .....
- ○ widowed since: .....

22. WITH WHOM DOES YOUR CHILD LIVE MOST OF THE TIME?

- ○ biological parents
- ○ biological mother
- ○ biological mother and her partner
- ○ adoptive parents
- ○ in a children's home
- ○ biological father
- ○ biological father and his partner
- ○ foster parents
- ○ grandparents or relatives
- ○ other: .....

23. WHO HAS CUSTODY OF THE CHILD?

- ○ both parents
- ○ mother
- ○ father
- ○ other attachment figure: .....

24. PLEASE NAME ALL SIBLINGS AND PEOPLE LIVING IN THE HOUSEHOLD WITH THE CHILD FOR AT LEAST ONE YEAR.

RELATIONSHIP STATUS WITH THE CHILD	DATE OF BIRTH
Example: Father	*17.02.1965*

25. PLEASE NAME ALL CLOSE RELATIVES/PEOPLE **NO LONGER** LIVING IN THE HOUSEHOLD WITH THE CHILD

RELATIONSHIP STATUS WITH THE CHILD	LIVES/WORKS	DATE OF BIRTH
Example: Brother	*At university in London for 2 years*	*15.08.1989*

YOUR CHILD'S MEDICAL HISTORY

GENERAL MEDICAL INFORMATION

26. PLEASE NAME ALL **PERMANENT OR WEARING** HEALTH PROBLEMS YOUR CHILD EXPERIENCED IN THE PAST OR IS CURRENTLY EXPERIENCING.

27. WAS YOUR CHILD EVER TREATED IN A HOSPITAL?

○ yes ○ no

If so, please enter the following information

WHEN	WHY?
Example: Summer 1999	*Newborn icterus*
Example: 07.–13.01.2008	*Examination due to abdominal pain*

28. DO ANY FAMILY MEMBERS OR CLOSE ATTACHMENT FIGURES (E.G. FRIENDS) HAVE **SEVERE OR CHRONIC DISEASES OR PAIN**?

○ yes ○ no

If so, please enter the following information:

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

29. CURRENTLY, IS THERE SEVERE STRAIN IN YOUR FAMILY OR IN YOUR CHILD'S LIFE?

○ yes ○ no

If so, please name these stressful events/situations (e.g.: divorce, separation, severe financial burden, illness, bullying, loss of a friend):

.....

.....

.....

.....

.....

30. DOES YOUR CHILD SUFFER FROM SLEEP DISTURBANCES?

○ yes ○ no

If so, since when? About: .....

If so, what kind of sleep disturbances:

○ problems falling asleep

○ problems sleeping through

○ others: .....

PREVIOUS EXAMINATIONS AND TREATMENTS

31. HAS YOUR CHILD TAKEN MEDICATION IN THE **PAST 3 MONTHS**?

○ yes ○ no

If so, please enter the following information:

DRUG	**DOSE RATE AND APPLICATION** (tablet, suppository, drops, puffs)	**HOW OFTEN PER DAY? AS REQUIRED?**	**WHY OR AGAINST WHAT? FOR HOW LONG?**	**HOW EFFECTIVE** 1 = not effective 2 = little effective 3 = very effective
Example: Ben-u-ron	*500 mg per tablet*	*as required*	*against pain for 8 weeks*	*2*
Example: Antibiotics	*Coated tablet*	*3x day*	*sinusitis for 10 days*	*3*

32. WERE FURTHER DRUGS **AGAINST PAIN** TAKEN **IN THE PAST**?

○ yes ○ no

If so, please enter the following information:

DRUG AND APPLICATION	**DOSE RATE PER DAY?** (tablet, suppository, drops, puffs)	**HOW OFTEN AS REQUIRED?**	**WHY OR AGAINST WHAT FOR HOW LONG?**	**HOW EFFECTIVE** 1 = not effective 2 = little effective 3 = very effective
Example: Ben-u-ron	*500 mg per tablet*	*as required*	*against pain February till October 2008*	*2*

33. TO DATE, WERE ANY EXAMINATIONS (OUTPATIENT AND/OR INPATIENT) CONDUCTED TO CLARIFY THE CAUSES OF PAIN?

◯ yes ◯ no

If so, please enter the following information

EXAMINATION	DATE	WHO CONDUCTED THE EXAMINATION?
Example: MRI/skull	*January 2008*	*Medical practice Dr. Smith / Glasgow*
Orthopedist	*February 2008*	*Orthopedic practice Dr. Miller / London*

34. WAS YOUR CHILD ALREADY DIAGNOSED WITH PAIN?

◯ yes ◯ no

If so, which one(s): .....

35. DID YOUR CHILD RECEIVE TREATMENT IN ORDER TO RELIEF THE PAIN (E.G. RELAXATION TECHNIQUES, ACUPUNCTURE, ELECTRIC NERVE STIMULATION (TENS), PHYSIOTHERAPY, MASSAGES, PSYCHOTHERAPY, INJECTIONS, NERVE BLOCKS WITH CATHETER, CURE/REHABILITATION, OPERATIONS)?

◯ yes ◯ no

If so, which one(s):

TIME PERIOD	TREATMENT / OPERATION	HOW EFFECTIVE 1 = not effective 2 = little effective 3 = very effective
Example: February till October 2008	*acupuncture*	*2*

36. SO FAR, HOW MANY DIFFERENT DOCTORS/THERAPISTS HAVE YOU CONSULTED DUE TO YOUR CHILD'S PAIN?

◯ none ◯ about ..... doctors/therapists

37. WHICH SPECIALIST HAS SO FAR EXAMINED OR TREATED YOUR CHILD'S PAIN?

◯ Pediatrician ◯ General practitioner ◯ (Child-)Neurologist

◯ Orthopedist ◯ Radiologist ◯ (Child-)Psychotherapist

◯ (Child-)Psychiatrist ◯ (Child-)Surgeon ◯ Pain Therapist

◯ alternative pract. ◯ Physiotherapist ◯ other: .....

38. HOW OFTEN DID YOU CONSULT A DOCTOR/THERAPIST TOGETHER WITH YOUR CHILD DUE TO PAIN **WITHIN THE PAST 3 MONTHS**?

◯ none ◯ about ..... appointments within the past 3 months

YOUR CHILD'S PAIN CHARACTERISTICS

YOUR CHILD'S PAIN HISTORY

39. WHEN DID YOUR CHILD'S **CURRENT PAIN PROBLEM** START?

.....

40. WHICH **COMPLAINTS** DID YOUR CHILD HAVE WHEN THE PAIN PROBLEM STARTED?

.....

.....

41. DID THE PAIN VARY IN INTENSITY?

◯ yes ◯ no

If so, please describe (Example: decreasing, increasing, permanently alternating, unvarying from the beginning, from April till June 2004 it was completely absent, and so on)?

.....

.....

42. AT THE TIME WHEN THE PAIN STARTED, WERE THERE ANY MAJOR OR SPECIFIC CHANGES IN YOUR LIFE OR YOUR CHILD'S LIFE?

◯ yes ◯ no

If so, please describe:

.....

.....

.....

CURRENT PAIN

43. HOW DO YOU NAME YOUR CHILD'S PAIN (E.G. HEADACHE, JOINT PAIN, ABDOMINAL PAIN, ACHING BACK, OR OTHER)? PLEASE NAME THE PAIN COMPLAINTS IN THE ORDER OF INTENSITY, THE STRONGEST PAIN FIRST.

Pain complaint No 1: .....

Pain complaint No 2: .....

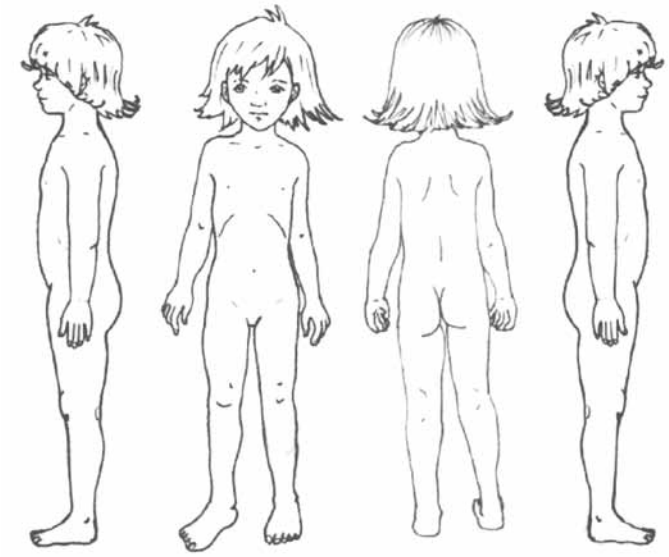
Pain complaint No 3: .....

Further pain complaints: .....

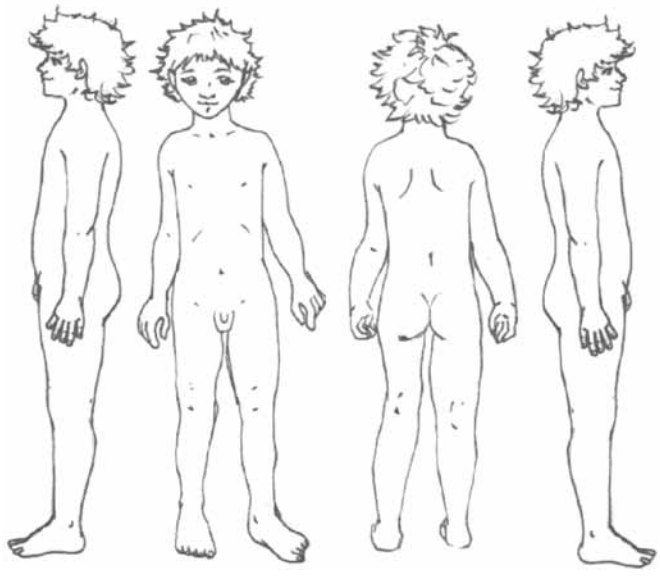
44. PLEASE MARK („X") YOUR CHILD'S PAIN AREA(S).

45. PLEASE ALSO MARK THE AREA WITH THE STRONGEST PAIN WITH A CIRCLE („○") **(MAIN PAIN LOCATION).**

GIRLS



BOYS



46. WHEN, IN THE COURSE OF A DAY, IS THE MAIN PAIN **MOST INTENSE**?

47. WHEN, IN THE COURSE OF A DAY, IS THE MAIN PAIN **LEAST INTENSE**?

48. WHEN, IN THE COURSE OF A WEEK, DOES YOUR CHILD HAVE THE **MOST** PAIN?

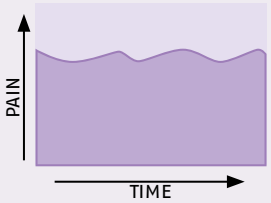
49. WHEN, IN THE COURSE OF A WEEK, DOES YOUR CHILD HAVE THE **LEAST** PAIN?

50. **AT WHICH TIME OF THE YEAR** OR IN **WHICH MONTH** DOES YOUR CHILD HAVE THE **MOST PAIN**?

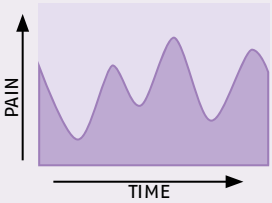
51. HOW OFTEN DOES YOUR CHILD'S **MAIN PAIN** (MARKED WITH A „○") OCCUR?

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

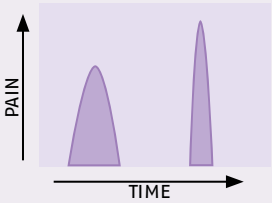
52. WHICH PICTURE BEST MATCHES YOUR CHILD'S MAIN PAIN IN THE **PAST 7 DAYS**?



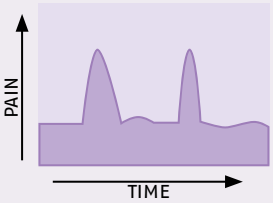
○ My Child has permanent pain. Pain intensity varies less.



○ 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.

53. DOES YOUR CHILD HAVE **PERMANENT** PAIN (I.E. THE PAIN IS **ALWAYS THERE** AND **NEVER GONE**)?

- ◯ No, the pain is sometimes there and sometimes gone
- ◯ Yes, the pain is always there and never gone

IN CASE YOUR CHILD HAS **PERMANENT** PAIN: FOR HOW LONG?

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

54. 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 diagramm).

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.

55. HOW STRONG WAS YOUR CHILD'S **STRONGEST** MAIN PAIN 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

56. 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

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

57. HOW STRONG WAS YOUR CHILD'S **STRONGEST MAIN PAIN** 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

58. 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

59. IS YOUR CHILD'S PAIN ACCOMPANIED BY ACCESSORY SYMPTOMS? (CHECK AS MANY AS APPLY)

- ◯ no accessory symptoms
- ◯ nausea
- ◯ vomiting
- ◯ light sensitivity
- ◯ sound sensitivity
- ◯ impaired vision
- ◯ dizzyness
- ◯ swelling
- ◯ redness
- ◯ weakness
- ◯ fast breathing
- ◯ tiredness
- ◯ tension
- ◯ sleep disturbances
- ◯ sweating
- ◯ constipation
- ◯ hypersensitivity of skin
- ◯ lack of concentration
- ◯ other: .....

.....

60. DO YOU NOTICE WHEN YOUR CHILD'S PAIN IS **COMING**?

◯ yes ◯ no

If so, what are the signs of coming pain (Example: stiffness, changes in mood or behaviour, physical sensation or certain statements)?

.....

.....

.....

.....

61. 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	○	○	○	○
killing	○	○	○	○
miserable	○	○	○	○
dreadful	○	○	○	○
horrible	○	○	○	○
tormenting	○	○	○	○
terrible	○	○	○	○
unbearable	○	○	○	○
burning	○	○	○	○
beating	○	○	○	○
stabbing	○	○	○	○
throbbing	○	○	○	○
pressing	○	○	○	○
pulsating	○	○	○	○

62. IF THIS IS ABOUT YOUR DAUGHTER:

Does she already get her period?

○ yes ○ no

If so, when did the period appear for the first time? .....

63. DOES THE PAIN OCCUR IN A TIME CONTEXT ALONG WITH THE PERIOD?

○ yes ○ no

If so:

○ often? ○ always?

FACTORS INFLUENCING THE PAIN

64. WHAT EASES AND WHAT EXACERBATES YOUR CHILD'S MAIN 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 child's pain cannot be influenced by anything:		○	○

65. DOES YOUR CHILD'S PAIN GET WORSE WHEN HE/SHE IS ...

	YES	NO		YES	NEIN
tired	○	○	angry	○	○
tensed	○	○	busy	○	○
bored	○	○	lonely	○	○
happy	○	○	mischievous	○	○
unhappy	○	○	nervous	○	○

66. DOES ANYTHING **TRIGGER** YOUR CHILD'S PAIN?

○ yes ○ no

If so, which trigger factors point to the main pain (e.g. lack of sleep, excitement, cold, physical activity, change in weather, light, noise, video games, TV, hectic activity, problems in school, weekend or start of holidays, ...)?

.....

.....

.....

.....

.....

HANDLING THE PAIN

67. WHAT DO YOU THINK ARE THE **REASONS** FOR YOUR CHILD'S MAIN PAIN?

68. WHAT DOES YOUR CHILD DO WHEN HE/SHE IS IN PAIN? PLEASE EXPLAIN:

69. HOW DO YOU REACT WHEN YOUR CHILD IS IN PAIN? PLEASE EXPLAIN:

YOUR EXPECTATIONS

70. HOW WOULD YOUR CHILD'S LIFE CHANGE IF THE CURRENT PAIN CONDITION DISAPPEARED?

71. HOW WOULD YOUR FAMILY LIFE CHANGE?

72. ASSUMING THAT THE PAIN WILL PERSIST: WHAT DO YOU THINK YOUR CHILD SHOULD DO **NOW** IN ORDER TO BE IN A BETTER SITUATION LATER?

GENERAL AND PHYSICAL IMPAIRMENT DUE TO PAIN

73. 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: daycare)	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?

.....

.....

.....

74. DID THE PAIN KEEP YOUR CHILD FROM DOING THINGS HE/SHE WANTED TO DO DURING **THE PAST 3 MONTHS**?

◯ yes ◯ no

If so, please explain:

.....

.....

.....

75. 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).

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

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

77. DID THE NUMBER OF DAYS ABSENT FROM SCHOOL/DAY CARE **INCREASE** DURING THE **PAST 4 WEEKS** COMPARED TO THE PAST 3 MONTHS?

◯ no ◯ yes

IF SO, HOW MANY DAYS DID YOUR CHILD NOT ATTEND SCHOOL (OR DAY CARE) DUE TO PAIN IN THE **PAST 4 WEEKS?**

◯ on …….. days my child did not attend school (day care).

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

◯ no ◯ yes, on …….. days

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

◯ no ◯ yes, on …….. days

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

◯ no ◯ yes, on …….. days

81. IS THERE ANYTHING ELSE YOU WISH TO TELL US – CONCERNING YOUR CHILD'S PAIN OR THE INFLUENCE THE PAIN HAS ON YOUR CHILD, YOU OR YOUR FAMILY?

THANK YOU!

German
Paediatric Pain Centre

Vestische Kinder- und
Jugendklinik Datteln
Universität Witten/Herdecke

universität
Witten/Herdecke

TRÄGER:
VESTISCHE CARITAS-KLINIKEN GMBH