NEPEAN PAIN MANAGEMENT
SCRAMBLER THERAPY PATIENT INFORMATION

The data collected before, during and after treatment with Scrambler Therapy will be de-identified and used for the purposes of Nepean Pain Management's investigator-lead clinical study. Please refer to the example consent form at the end of this questionnaire for further information. You will be asked to sign this form at attendance for Scrambler Therapy.

<table>
<tr><td colspan="3">PATIENT INFORMATION</td></tr>
<tr><td>Title:</td><td>Surname:</td><td>Given name(s):</td></tr>
<tr><td>Gender: M / F</td><td>Date of birth: / /
Age:</td><td>Today's date: / /</td></tr>
<tr><td colspan="3">Medicare Card number:
Patient reference number:
Expiry:</td></tr>
<tr><td colspan="3">Residential address:
Street: ……………………………………………………………………………………
City/Suburb: ……………………………. State: …………… Postcode: ……………………</td></tr>
<tr><td colspan="3">Contact details: Home phone: …………………………. Mobile: …………………………
Email: ……………………………………………………………………………………..</td></tr>
<tr><td colspan="3">Country of birth: ………………………………………………………………………</td></tr>
<tr><td colspan="3">Do you identify as Aboriginal or Torres Strait Islander? Y / N ………………………..</td></tr>
<tr><td colspan="3">Do you require an interpreter? Y / N If yes specify language: ………………………..</td></tr>
<tr><td colspan="3">Are you hearing or sight impaired? Y / N</td></tr>
<tr><td colspan="3">Do you require help with written or spoken communication? Y / N</td></tr>
<tr><td>Height: ………………cm</td><td>Weight: …………………kg</td><td></td></tr>
</table>

Which of the following best describes your current work status?

- Full time paid employment
- Unemployed due to pain
- On leave from work due to pain
- Part time employment (…….hours)
- Retraining
- Unemployment (not pain related)
- Studying (eg school, TAFE, university)
- Retired
- Home duties
- Volunteer work

Does your pain affect the number of hours you are able to work or study? Y / N

Does your pain affect the type of work you are able to do? Y / N

What was the date of your injury? / /

Please provide a short description of how the pain commenced:

How long has the pain been present?

- Less than 3 months
- 3-6 months
- 6-12 months
- More than 1 year
- More than 2 years
- More than 3 years
- More than 4 years
- More than 5 years
- More than 10 years

What statement best describes your pain?

- Always present (always the same intensity)
- Always present (level of pain varies)
- Often present (pain-free periods last less than 6 hours)
- Occasionally present (pain occurs once to several times per day)
- Rarely present (pain occurs every few days or weeks)

Past medical history:

Heart disease including recent myocardial infarction (heart attack) or heart failure
Epilepsy
High blood pressure
Lung disease
Diabetes
Stroke or neurological condition
Ulcer or stomach disease
Kidney disease
Cancer
Depression or anxiety
Anaemia or blood disease
Osteoarthritis / degenerative arthritis
Rheumatoid arthritis

Past surgical history:

Heart surgery
Lung surgery
Joint replacement
Gastrointestinal surgery
Other: ____

Please tick if you have implanted:

Pacemaker
Aneurysm clips
Vena cava clips
Skull plates

For female patients:

Are you currently pregnant?
Are you currently breastfeeding?

MEDICATION USE

List all the medications you are taking (include all prescription and over the counter medicines). There is more space on the following page.

Medicine name (as on the label)	Medication strength (as on the label)	At what times do you take this medication?	How many do you take at these times?

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PAIN QUESTIONS

PAIN DETECT CHECK-IN

1. How would you describe your pain now, at this moment?

   0 1 2 3 4 5 6 7 8 9 10

2. How strong was the strongest pain during the last 4 weeks?

   0 1 2 3 4 5 6 7 8 9 10

3. How strong was the pain during the past 4 weeks on average?

   0 1 2 3 4 5 6 7 8 9 10

4. Mark the picture that best describes your pain

☐ Persistent pain with slight fluctuations

☐ Persistent pain with pain attacks

☐ Pain attacks without pain between them

☐ Pain attacks with pain between them

5. Do you suffer from a burning sensations in the area of pain?

   Never Hardly noticed Slightly Moderately Strongly Very Strongly

6. Do you have a tingling or prickling sensation in the area of pain?

   Never Hardly noticed Slightly Moderately Strongly Very Strongly

7. Is light touching (clothing, blanket) on this area painful?

   Never Hardly noticed Slightly Moderately Strongly Very Strongly

8. Do you have sudden attacks of pain in the area like electric shocks?

   Never Hardly noticed Slightly Moderately Strongly Very Strongly

9. Is cold or heat (bath water) in this area occasionally painful?

   Never Hardly noticed Slightly Moderately Strongly Very Strongly

10. Do you suffer from a sensation of numbness in the area of pain?

    Never Hardly noticed Slightly Moderately Strongly Very Strongly

11. Does slight pressure in this area e.g. with a finger, trigger pain?

    Never Hardly noticed Slightly Moderately Strongly Very Strongly

DN4

1. Does the pain have one or more of the following characteristics?

Burning	Yes	No
Painful cold	Yes	No
Electric shocks	Yes	No

2. Is the pain associated with one or more of the following symptoms in the same area?

Tingling	Yes	No
Pins and needles	Yes	No
Numbness	Yes	No
Itching	Yes	No

3. Do you have reduced sensation:

to touch	Yes	No
to pinprick/sharp touch	Yes	No

4. In the painful area, can the pain be caused or increased by:

brushing	Yes	No

BRIEF PAIN INVENTORY

1. Rate your pain by circling the one number that best describes the following: Circle one of the numbers on the scale next to each item 0 = no pain and 10 = pain as bad as you can imagine											
a) your pain at its WORST last 24 hours?	0	1	2	3	4	5	6	7	8	9	10
b) your pain at its LEAST in the last 24 hours?	0	1	2	3	4	5	6	7	8	9	10
c) your pain on AVERAGE in the last 24 hours?	0	1	2	3	4	5	6	7	8	9	10
d) how much pain do you have RIGHT NOW?	0	1	2	3	4	5	6	7	8	9	10

2. In the past 24 hours, how much relief have you gained from pain treatments or medications?										
0	10	20	30	40	50	60	70	80	90	100%

3. During the past 24 hours, <u>how much has pain interfered with</u> the following: Circle one of the numbers on the scale next to each item 0 = does not interfere and 10 = completely interferes											
a) your general activity?	0	1	2	3	4	5	6	7	8	9	10
b) your mood?	0	1	2	3	4	5	6	7	8	9	10
c) your walking ability?	0	1	2	3	4	5	6	7	8	9	10
d) your normal work (includes housework)?	0	1	2	3	4	5	6	7	8	9	10
e) your relationships with other people?	0	1	2	3	4	5	6	7	8	9	10
f) your sleep?	0	1	2	3	4	5	6	7	8	9	10
g) your enjoyment of life?	0	1	2	3	4	5	6	7	8	9	10

DASS21

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any one statement.

The rating scale is as follows:
0 Did not apply to me at all
1 Applied to me to some degree
2 Applied to me to a considerable degree, or a good part of the time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0 1 2 3
2	I was aware of dryness of my mouth	0 1 2 3
3	I couldn't seem to experience any positive feeling at all	0 1 2 3
4	I experienced breathing difficulty (eg excessively rapid breathing, breathlessness in the absence of physical exertion)	0 1 2 3
5	I found it difficult to work up the initiative to do things	0 1 2 3
6	I tended to over-react to situations	0 1 2 3
7	I experienced trembling (eg in the hands)	0 1 2 3
8	I felt that I was using a lot of nervous energy	0 1 2 3
9	I was worried about situations in which I might panic and make a fool of myself	0 1 2 3
10	I felt that I had nothing to look forward to	0 1 2 3
11	I found myself getting agitated	0 1 2 3
12	I found it difficult to relax	0 1 2 3
13	I felt down-hearted and blue	0 1 2 3
14	I was intolerant of anything that kept me from getting on with what I was doing	0 1 2 3
15	I felt I was close to panic	0 1 2 3
16	I was unable to be enthusiastic about anything	0 1 2 3
17	I felt I wasn't worth much as a person	0 1 2 3
18	I felt that I was rather touchy	0 1 2 3
19	I was aware of the action of my heart in the absence of physical exertion (eg sense of heart rate increase, heart missing a beat)	0 1 2 3
20	I felt scared without any good reason	0 1 2 3
21	I felt that life was meaningless	0 1 2 3

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE