Spine Service

Department of Orthopaedic Surgery
St George Hospital Campus

Phone: (02) 8566 7166 Fax: (02) 8566 7177 www.spine-service.org info@spine-service.org @DiwanSpineLabs

Patient Information & Evaluation Booklet

Your appointment with Dr Ashish Diwan is at:

☐ **Kogarah** St George Private Hospital, Level 5, Suite 16, 1 South Street.

☐ **Campbelltown** Centric Building A, Level 1, Suite 127, 4 Hyde Parade.

☐ **Bowral** 21 St. Jude Street.

Date | | | | | | | (D D M M Y Y) **Time** | | | | | (H H M M) **am / pm**

What to bring to your first appointment

It is essential that you bring:

1. A referral letter from your GP (12 months validity), or a Specialist (3 months validity).
2. All available scans & X-rays of your spine
3. Any available medical reports that you may have pertinent to your consult

Costs

Initial consultation: $330 - Follow-up Consultations: $180

Workers compensation:

It is your responsibility to obtain approval in writing from your Insurer for the consult. Either bring this with you to your appointment, or have it sent directly to our rooms beforehand. We can then bill your Insurer directly. If you do not have insurer approval you will be required to pay the worker's compensation fee rate before seeing the doctor.

CTP / Third Party:

We do not accept CTP (Compulsory Third party) claims. You are very welcome to consult as a private patient, and pay workers compensation rates for appointments. We reserve the right to back charge workers compensation rates if applicable.

Spine Service

Spine Service at the Department of Orthopaedic Surgery, St George Hospital Campus is dedicated to the care of patients with neck and back-related symptoms. We specialise in degeneration and deformity of the spinal column. **The Service is truly integrated** and provides spinal diagnosis, spinal surgical care, pain pharmacotherapy, spinal injection, spinal education, spinal rehabilitation, spinal pain counselling and gym based fitness programs in association with numerous rehab teams.

Ashish Diwan (PhD FRACS FAOrthA) is the chief of the Spine Service at the Department of Orthopaedic Surgery, St. George Hospital. Following his orthopaedic surgical training at St George he has had advanced spinal surgical training at the Hospital for Special Surgery (HSS), Cornell University, New York, NY. The Hospital for Special Surgery is the oldest and largest orthopaedic hospital in the USA. During this stay at HSS Dr Diwan was awarded the prestigious Philip D. Wilson award and also the National Orthopaedic Fellows Foundation award for his achievements at the HSS. He is also a Merrill Lynch global innovations awardee for his research work. Dr Diwan specializes in surgery for degenerative disorders of the back and neck and in spinal deformities (scoliosis & kyphosis). His expertise includes minimally invasive intradiscal treatments, microscopic spinal decompression, spinal stabilization using CT-guided technology, anterior and posterior surgery for adult spinal deformity and disc replacement. His team has won numerous prizes for spinal research including the ISSLS prize.

What to expect at your first appointment

The first visit helps the spine service team to evaluate your problem and determine what course of treatment that is best for you. You should set aside two hours from arrival to departure for the first consultation.
This process is comprehensive and may include the filling out of questionnaires, a full medical history, and a physical examination where you may be required to undress (a gown is provided).
Please let the team know if you wish for someone to be present during this examination.
This is followed by studying your diagnostic tests that you have had, (or requesting others that may include x-rays, CT Scans, myelogram, MRI Scans, EMG / nerve conduction study, bone density test, blood tests, etc.) Following this Dr Diwan will discuss the possible treatment options for you. These options could include:

- Rehabilitation and physical therapy, pain counselling, spinal injections.
- Minimally invasive spinal procedure(s).
- Microdiscectomy or spinal column decompression surgery.
- Decompression with spinal stabilization by way of CT guided, minimally invasive fusion surgery.
- Disc replacement surgery.

Follow-up appointments

- Prior to leaving the office, collect your investigations and book your follow-up appointment in advance.
- Always bring your x-rays and scans to all follow up appointments.

When you require educational material

Taking good care of the injured back is important to prevent recurrence and also to help heal the injured tissue.
We may direct you to the website www.spineservice.com.au or email educational material to you.

When you require surgery

If it is decided that you need surgery you will be given reading material. The Clinical Nurse will discuss the procedure in detail at a pre-surgical conference with you. At this stage all your blood tests and medical clearances are reviewed. You will have a chance to ask questions prior to signing a consent form to proceed with surgery. A quote for your surgery will also be provided.

When you need administrative assistance

Phone: (02) 8566 7166
Email: info@spine-service.org
Monday to Friday: 8:30am - 4.30pm.

We believe in providing you with the best care and hence have invested significant resources into research, which is performed at SpineLabs. Our training program is supported by the UNSW Foundation, which also receives donations on our behalf.

Patient Information Sheet

MUST BE COMPLETED IN FULL & SIGNED BY PATIENT OR GUARDIAN **STID:**

If patient is under the age of 16 years, please also advise parental details

Name: ……
SURNAME FIRST NAME

Pronouns: ( )She/Her ( )He/Him ( )They/Them **Sex recorded at birth:** ( ) Female ( ) Male

Address: ……

Age: …… **Date of Birth**: …… **Occupation**: ……

Phone (Home): (…..)…… (Work): (……)……

Mobile: …… **Email**: ……

Medicare No: …… Your position on Card: 1 / 2 / 3 / 4 / 5 Expiry Date ……

Private Health Insurance Fund: …… Membership No: ……

Veteran's Affairs No:…… **Age Pension** No:……

REFERRED BY: Dr …… Referral Date: ……

Referring Doctor's Address: ……

YOUR GP: : Dr …… Phone……

GP's Address: ……
(We need this, even if you were referred by another doctor).

NAME & ADDRESS OF **PHYSIOTHERAPIST** TREATING YOU (If any): ……

……

WORKERS' COMPENSATION Separate injuries / Claims MUST be advised.

EMPLOYER ……

Address: ……

Phone Number: (…..)…… Date of Injury: ……

INSURANCE Company: …… Branch: ……

Address: ……

Claim Manager: …… Phone Number: (…..)……

Claim No: …… Fax Number (…..)……

SOLICITOR Name & Address:……

……Phone: (…..) … ……

Statement

Spine Service is committed to ensuring the confidentiality and security of your personal information, in line with the privacy act covering all personal information held by organisations. These laws regulate the way we (Spine Service) collect, use, disclose, keep secure and provide patients access to their own information. In order to comply with the Privacy act, we by law are required to advise you that Spine Service will collect and hold personal information about you in the form of patient history, physical findings, investigation reports, communications related to your condition with other health providers, questionnaires as well as on going treatment data.

The primary reason we collect and hold personal information is for; Administration of the practice, Billing, including compliance with Medicare and Health Insurance Commission requirements, secure accurate patient history and information related to their condition, Gather de-identified research or audit statistics

In order to assist Spine Service in establishing, administering and maintaining these services it may be necessary to disclose personal information to certain third parties. Examples of the types of organisations to whom we may disclose your information include: Doctors and specialists outside the practice who may become, or are already involved in your care, locums and registrars attached to the practice for the purpose of teaching, insurance companies for workers compensation and work cover, hospital departments and administration, Spine Service administration, physiotherapy and rehabilitation services and similar organisations.

We will only disclose your information to these organisations to enable them to undertake specific treatment and administration services relevant to your care. You may access information held by us regarding your treatment and care by contacting the practice. You are not obligated to provide any information requested by Spine Service however without your consent Spine Service will be restricted in the practice's ability to provide the quality of health care and treatment you require.

You may be contacted by Research Staff from Spine Service about participating in ongoing research.

I acknowledge that I have read and understood the Privacy Statement above. I accept that the collection, use and disclosure of my personal information is necessary for the purpose of establishing, administering and maintaining treatment /care provided to me by Spine Service. I understand and agree to pay all fees relating to my condition, including where my health fund or insurance claim is declined for any reason.

Name: _____ Signature:_____ Date: _____/_____/_____

Spine Service

Department of Orthopaedic Surgery
St George Hospital Campus
University of New South Wales

Please fill in the circles below

Date	STID
Name	

Your problem relates to
Low back ○ Right leg ○ Left leg ○ Neck ○ Right arm/hand ○ Left arm/hand ○

When did your problem start? ……..

Please **describe how your problem started**

_____

_____

_____

How often do you have pain?	Never	Infrequently (1/4 months)	Sometimes (Once a month)	Often (Once a week)	Most of the time (Daily)	All the time
Low back and/or **buttock** pain	○	○	○	○	○	○
Leg pain	○	○	○	○	○	○
Numbness or tingling in **leg or foot**	○	○	○	○	○	○
Weakness in **leg or foot**	○	○	○	○	○	○
Neck pain	○	○	○	○	○	○
Arm pain	○	○	○	○	○	○
Numbness or tingling in **arm or hand**	○	○	○	○	○	○
Weakness in **arm or hand**	○	○	○	○	○	○

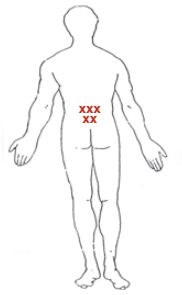
How **bothersome** are your symptoms?

- ○ Not at all
- ○ Slightly, but I can live with it
- ○ Somewhat, but I am managing
- ○ A fair bit, I need medications or other types of treatment
- ○ A lot, it is very disrupting

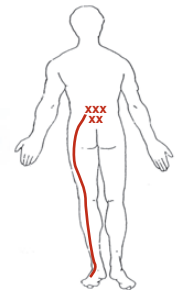
On a scale of 0 to 10, where **0 is no discomfort and 10 is unbearable**, how bad is the pain in your

	0	1	2	3	4	5	6	7	8	9	10
Low back	○	○	○	○	○	○	○	○	○	○	○
Right leg	○	○	○	○	○	○	○	○	○	○	○
Left leg	○	○	○	○	○	○	○	○	○	○	○
Neck	○	○	○	○	○	○	○	○	○	○	○
Right arm	○	○	○	○	○	○	○	○	○	○	○
Left arm	○	○	○	○	○	○	○	○	○	○	○

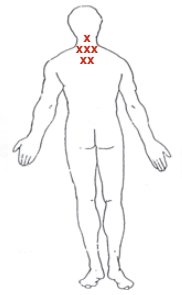
Please select the image that best represents the **location/distribution** of your symptoms:



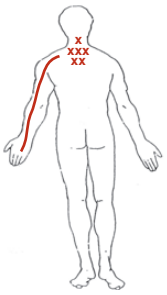
○ 1



○ 2



○ 3



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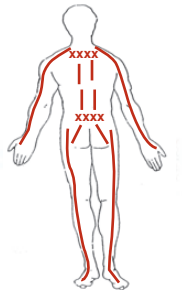

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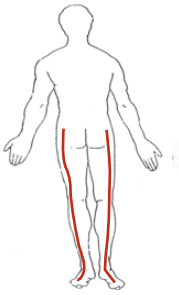

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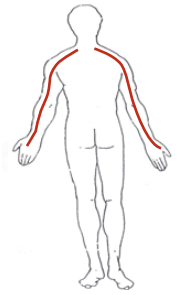
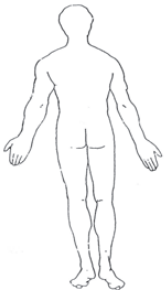


○ 7



○ 8

Which of the following **best describes your symptoms**?

	Not at all	Somewhat	Strongly
Aching	○	○	○
Numbness	○	○	○
Pins/ Needles	○	○	○
Burning	○	○	○
Stabbing	○	○	○

More about your symptoms:

			While _____ the pain is:	better	worse	no difference
Does your pain disturb sleep?	No ○	Yes ○	coughing	○	○	○
Do you have bowel problems?	No ○	Yes ○	straining	○	○	○
Do you have bladder problems?	No ○	Yes ○	sitting	○	○	○
Do you have stiffness in the morning?	No ○	Yes ○	standing	○	○	○
Is it worse at the end of the day?	No ○	Yes ○				

What **type of medication** are you taking for your spine problem?

- ○ Panadol/Paracetamol/Acetaminophen
- ○ Non-Prescribed anti inflammatories (Nurofen, Ibuprofen, Diclofenac, Naproxen, Aleve)
- ○ Prescribed anti inflammatories (Mobic, Celebrex)
- ○ Opioids (Endone, Palexia, Tramadol, Morphine, Oxycodone, Targin)
- ○ Neuromodulating agents (Lyrica, Pregabalin)
- ○ Muscle relaxants
- ○ Benzodiazepines (Temazepam, Diazepam, Alprazolam, Lorazepam, Clonazepam)
- ○ Other:_____

During the past one week **how often** have you taken your medications?

Not at all ○ Once a week ○ Once every couple of days ○ Once or twice a day ○ 3 or more times a day ○

Does the medication:

- ○ Relieve your symptoms a great deal
- ○ Relieve symptoms somewhat
- ○ Has/have no effect
- ○ Symptoms are somewhat worse
- ○ Symptoms are much worse

During the past month	None (0 days)	Slightly (1-4 days)	Moderately (5-14 days)	Quite a bit (15-25 days)	Extremely (25-30days)
How much did pain interfere with your normal job?	○	○	○	○	○
How much did pain interfere with your work at home?	○	○	○	○	○
How much did pain interfere with your recreational activities?	○	○	○	○	○
How much did pain interfere with your social activities with family, friends, neighbours and groups?	○	○	○	○	○
How many days did your pain keep you in bed for most of the day?	○	○	○	○	○
How many days did your pain keep you from going to work?	○	○	○	○	○
How many days did you do half as much as usual due to pain?	○	○	○	○	○

	Yes, Limited a **lot**	Yes, Limited a **little**	No, **Not limited** at all
Vigorous activities, like running, lifting heavy objects, participating in strenuous sports	○	○	○
Moderate activities, like moving a table, pushing a vacuum cleaner, bowling or playing golf	○	○	○
Lifting or carrying groceries	○	○	○
Climbing several flights of stairs	○	○	○
Climbing one flight of stairs	○	○	○
Bending, kneeling or stooping	○	○	○
Walking more than a kilometre and half	○	○	○
Walking several blocks	○	○	○
Walking one block	○	○	○
Sitting in a chair	○	○	○
Standing erect or straight	○	○	○
Lying down on your back	○	○	○
Lying on your stomach	○	○	○
Lying on your sides	○	○	○
Bathing or dressing yourself	○	○	○
Sexual activities	○	○	○
Do you have trouble in “starting to walk” (initiating gait)?	○	○	○
Do you have trouble crossing the street at lights?	○	○	○

Have you had the following treatment for your spinal problem	No	Yes	If yes, when and for how long
Aerobic exercise (like walking, swimming)	○	○	
Back or neck exercises	○	○	
Physical therapy (local heat)	○	○	
Traction	○	○	
Corset or brace	○	○	
Spinal manipulation	○	○	

Massage therapy	○	○	
Acupuncture	○	○	
TENS	○	○	
Osteopathy	○	○	
Injection into the disc	○	○	
Epidural steroid injections	○	○	
Injection into the muscles	○	○	
Spinal surgery	○	○	If yes how many/when
Pain clinic	○	○	

For your spinal problem, have you seen a	No	Yes	If yes, please provide their name and their advice
General practitioner	○	○	
Sports medicine specialist	○	○	
Physiotherapist	○	○	
Chiropractor	○	○	
Osteopath	○	○	
Rheumatologist	○	○	
Neurologist	○	○	
Orthopaedic surgeon	○	○	
Neurosurgeon	○	○	
Insurance doctor	○	○	
Others 1	○	○	
Others 2	○	○	

Have you had or have	No	Yes	If yes, what is the problem, who manages it, what treatment are you on?
High blood pressure	○	○	
Diabetes	○	○	
Heart disease	○	○	
Lung disease (COPD, asthma, others)	○	○	
Depression	○	○	
Other mental health disorder	○	○	
Rheumatoid arthritis	○	○	
Ulcers or stomach disease	○	○	
Kidney disease	○	○	
Liver disease	○	○	
Peripheral vascular disease	○	○	
Cancer	○	○	
Other	○	○	

Past Surgical History (Please provide a list of the dates and operations you have had)

_____

_____

_____

_____

_____

Regular medications (other than for pain)**:** _____

_____

Do you have any allergies? No ○ Yes ○ If yes provide details _____

Do you have a **family history** of:

Diabetes: ____ Spinal disorders: ____ Clotting disorders: ____ Others: _____

Do you smoke / Did you previously smoke?
No ○ Yes ○ (includes vaping and shishas)
How many cigarettes per day: _____
How many years:_____
When did you stop?_____

Do you drink alcohol? / Did you use to drink alcohol?
No ○ Yes ○
How many standard drinks per day / week:_____
How many years:_____
When did you stop?_____

Which of the following best describes your marital situation?
Single ○ | Living with significant other ○ | Married ○ | Widowed ○ | Divorced/seperated ○

What best describes your work status?
Full time ○ Unemployed ○ Paid leave ○ Disabled ○ Student ○
Part time ○ Retired not health related ○ Unpaid leave ○ Homemaker ○ Other ○

Who has accompanied you today? _____

Have there been recent stresses in your relationships or family life (financial or emotional)
No ○ | Mild stress ○ | Moderate stress ○ | High stress ○

Are you considering or have you taken legal action for your spine related problems?
No ○ | I am considering a lawyer ○ | My legal action is pending ○
It has been resolved **but not** in my favour ○ | It has been resolved in my favour ○

The following sections are standardised international questionnaires, used to monitor your progress:

EQ5D*:* Please select the statement that best describes your health:

Mobility
- o I have no problems in walking about
- o I have some problems in walking about
- o I am confined to bed

Pain / Discomfort
- o I have no pain or discomfort
- o I have moderate pain or discomfort
- o I have extreme pain or discomfort

Self-Care
- o I have no problems with self-care
- o I have some problems washing or dressing myself
- o I am unable to wash or dress myself

Anxiety / Depression
- o I am not anxious or depressed
- o I am moderately anxious or depressed
- o I am extremely anxious or depressed

Usual Activities (e.g. work, study, housework, family or leisure)
- o I have no problems with performing my usual activities
- o I have some problems with performing my usual activities
- o I am unable to perform my usual activities

Oswestry Disability Index

Please answer the following questions **only if you have pain in your lower back**.
Please only select one option per question.

1 – Pain Intensity

- o I have no pain at the moment.
- o The pain is very mild at the moment
- o The pain is moderate at the moment.
- o The pain is fairly severe at the moment.
- o The pain is very severe at the moment.
- o The pain is the worst imaginable at the moment.

2 – Personal Care (washing, dressing, etc.)

- o I can look after myself normally without causing extra pain.
- o I can look after myself normally but it causes extra pain.
- o It is painful to look after myself and I am slow and careful.
- o I need some help but manage most of my personal care.
- o I need help every day in most aspects of self care.
- o I do not get dressed, I wash with difficulty and stay in bed.

3 – Lifting

- o I can lift heavy weights without extra pain.
- o I can lift heavy weights but it gives extra pain.
- o Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- o Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- o I can lift only very light weights.
- o I cannot lift or carry anything at all.

4 – Walking

- o Pain does not prevent me walking any distance.
- o Pain prevents me walking more than 1.6 km.
- o Pain prevents me walking more than 400 metres.
- o Pain prevents me walking more than 90 metres.
- o I can only walk using a stick or crutches.
- o I am in bed most of the time and have to crawl to the toilet.

5 – Sitting

- o I can sit in any chair as long as I like.
- o I can sit in my favorite chair as long as I like.
- o Pain prevents me from sitting for more than 1 hour.
- o Pain prevents me from sitting for more than ½ hour.
- o Pain prevents me from sitting for more than 10 minutes.
- o Pain prevents me from sitting at all.

6 – Standing

- o I can stand as long as I want without extra pain.
- o I can stand as long as I want but it gives me extra pain.
- o Pain prevents me from standing more than 1 hour.
- o Pain prevents me from standing for more than ½ an hour.
  Pain prevents me from standing for more than 10 minutes.
- o Pain prevents me from standing at all

7 – Sleeping

- o My sleep is never disturbed by pain.
- o My sleep is occasionally disturbed by pain.
- o Because of pain, I have less than 6 hours sleep.
- o Because of pain, I have less than 4 hours sleep.
- o Because of pain, I have less than 2 hours sleep.
- o Pain prevents me from sleeping at all.

8 – Sex life (if applicable)

- o My sex life is normal and causes no extra pain.
- o My sex life is normal but causes some extra pain.
- o My sex life is nearly normal but is very painful.
- o My sex life is severely restricted by pain.
- o My sex life is nearly absent because of pain.
- o Pain prevents any sex life at all.

9 – Social Life

- o My social life is normal and cause me no extra pain.
- o My social life is normal but increases the degree of pain.
- o Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
- o Pain has restricted my social life and I do not go out as often.
- o Pain has restricted social life to my home
- o have no social life because of pain.

10 – Traveling

- o I can travel anywhere without pain.
- o I can travel anywhere but it gives extra pain.
- o Pain is bad but I manage journeys of over two hours.
- o Pain restricts me to short necessary journeys under 30 minutes.
- o Pain prevents me from traveling except to receive treatment.

Neck Disability Index

Please answer the following questions **only if you have neck pain.**
Please only select one option per question.

1 – Pain Intensity
- o I have no pain at the moment.
- o The pain is very mild at the moment.
- o The pain is moderate at the moment.
- o The pain is fairly severe at the moment.
- o The pain is very severe at the moment.
- o The pain is the worst imaginable at the moment.

2 – Personal Care (Washing, Dressing, etc.)
- o I can look after myself normally without causing extra pain.
- o I can look after myself normally but it causes extra pain.
- o It is painful to look after myself and I am slow and careful.
- o I need some help but manage most of my personal care.
- o I need help every day in most aspects of self care.
- o I do not get dressed, I wash with difficulty and stay in bed.

3 – Lifting
- o I can lift heavy weights without extra pain.
- o I can lift heavy weights but it gives extra pain.
- o Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- o Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- o I can lift very light weights.
- o I cannot lift or carry anything at all.

4 – Reading
- o I can read as much as I want to with no pain in my neck.
- o I can read as much as I want to with slight pain in my neck.
- o I can read as much as I want with moderate pain in my neck.
- o I cannot read as much as I want because of moderate pain in my neck.
- o I can hardly read at all because of severe pain in my neck.
- o I cannot read at all.

5 – Headaches
- o I have no headaches at all.
- o I have slight headaches that come infrequently.
- o I have moderate headaches which come infrequently.
- o I have moderate headaches which come frequently.
- o I have severe headaches which come frequently.
- o I have headaches almost all the time.

6 – Concentration
- o I can concentrate fully when I want to with no difficulty.
- o I can concentrate fully when I want to with slight difficulty.
- o I have a fair degree of difficulty in concentrating when I want to.
- o I have a lot of difficulty in concentrating when I want to.
- o I have a great deal of difficulty in concentrating when I want to.
- o I cannot concentrate at all.

7 – Work
- o I can do as much work as I want to.
- o I can do my usual work, but no more.
- o I can do most of my usual work, but no more.
- o I cannot do my usual work.
- o I can hardly do any work at all.
- o I cannot do any work at all.

8 – Driving
- o I can drive my car without any neck pain.
- o I can drive my car as long as I want with slight pain in my neck.
- o I can drive my car as long as I want with moderate pain in my neck.
- o I cannot drive my car as long as I want because of moderate pain in my neck.
- o I can hardly drive at all because of severe pain in my neck.
- o I cannot drive my car at all.

9 – Sleeping
- o I have no trouble sleeping.
- o My sleep is slightly disturbed (less than 1 hour sleepless).
- o My sleep is mildly disturbed (1-2 hours sleepless).
- o My sleep is moderately disturbed (2-3 hours sleepless).
- o My sleep is greatly disturbed (3-5 hours sleepless).
- o My sleep is completely disturbed (5-7 hours sleepless).

10 – Recreation
- o I am able to engage in all my recreation activities with no neck pain at all.
- o I am able to engage in all my recreation activities, with some pain in my neck.
- o I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck.
- o I am able to engage in a few of my usual recreation activities because of pain in my neck.
- o I can hardly do any recreation activities because of pain in my neck.
- o I cannot do any recreation activities at all.

painDETECT

PAIN QUESTIONNAIRE

Date: _____ **Patient:** **Last name:** _____ **First name:** _____

How would you assess your pain **now**, at this moment?

0 1 2 3 4 5 6 7 8 9 10

none max.

How strong was the **strongest** pain during the past 4 weeks?

0 1 2 3 4 5 6 7 8 9 10

none max.

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

0 1 2 3 4 5 6 7 8 9 10

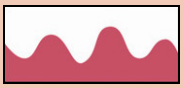
none max.

Mark the picture that best describes the course of your pain:

Persistent pain with slight fluctuations ☐

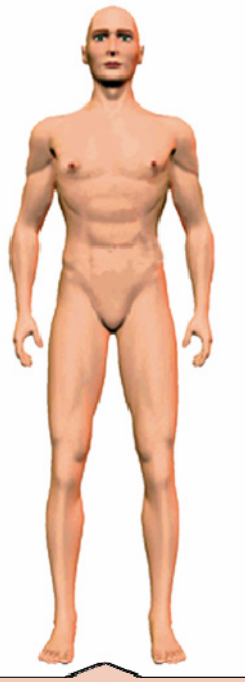
Persistent pain with pain attacks ☐

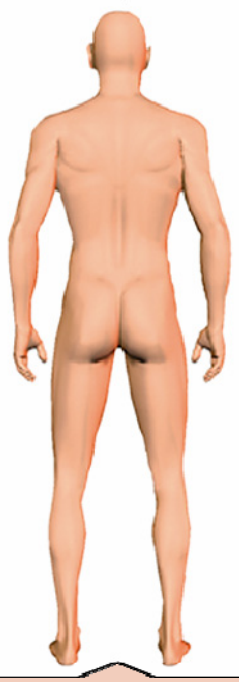
Pain attacks without pain between them ☐



Pain attacks with pain between them ☐

Please mark your **main area of pain**





Does your pain radiate to other regions of your body? yes ☐ no ☐

If yes, please draw the direction in which the pain radiates.

Do you suffer from a burning sensation (e.g., stinging nettles) in the marked areas?

never ☐ hardly noticed ☐ slightly ☐ moderately ☐ strongly ☐ very strongly ☐

Do you have a tingling or prickling sensation in the area of your pain (like crawling ants or electrical tingling)?

never ☐ hardly noticed ☐ slightly ☐ moderately ☐ strongly ☐ very strongly ☐

Is light touching (clothing, a blanket) in this area painful?

never ☐ hardly noticed ☐ slightly ☐ moderately ☐ strongly ☐ very strongly ☐

Do you have sudden pain attacks in the area of your pain, like electric shocks?

never ☐ hardly noticed ☐ slightly ☐ moderately ☐ strongly ☐ very strongly ☐

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

never ☐ hardly noticed ☐ slightly ☐ moderately ☐ strongly ☐ very strongly ☐

Do you suffer from a sensation of numbness in the areas that you marked?

never ☐ hardly noticed ☐ slightly ☐ moderately ☐ strongly ☐ very strongly ☐

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

never ☐ hardly noticed ☐ slightly ☐ moderately ☐ strongly ☐ very strongly ☐

(To be filled out by the physician)

never	hardly noticed	slightly	moderately	strongly	very strongly
☐ x 0 = 0	☐ x 1 = ☐	☐ x 2 = ☐☐	☐ x 3 = ☐☐	☐ x 4 = ☐☐	☐ x 5 = ☐☐

Total score ☐☐ **out of 35**

R. Freynhagen, R. Baron, U. Gockel,T.R. Tölle, CurrMed ResOpin Vol 22, 2006, 1911-1920

painDETECT

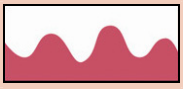
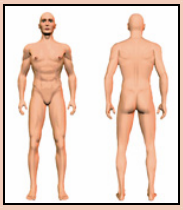
SCORING OF PAIN QUESTIONNAIRE

Date: ..... Patient: Last name: ..... First name: .....

Please transfer the total score from the pain questionnaire:

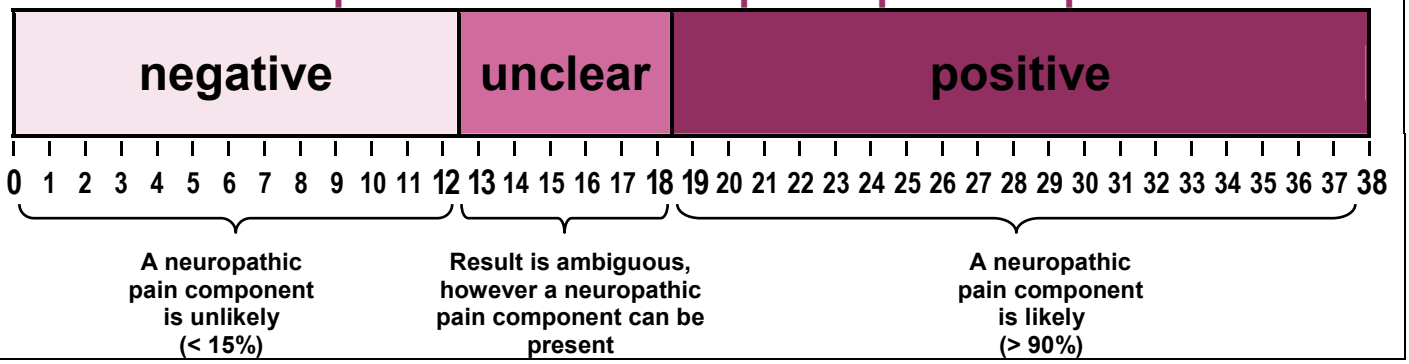
Total score ☐☐

Please add up the following numbers, depending on the marked pain behavior pattern and the pain radiation. Then total up the final score:

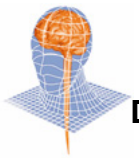
	Persistent pain with slight fluctuations	0	
	Persistent pain with pain attacks	-1	if marked, or
	Pain attacks without pain between them	+1	if marked, or
	Pain attacks with pain between them	+1	if marked
	Radiating pains?	+2	if yes
	Final score	☐☐	

Screening Result

on the presence of a neuropathic pain component



This sheet does not replace medical diagnostics.
It is used for screening the presence of a neuropathic pain component.



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NOTES