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Demographics

Service Number 8

Age 88

Gender

- (•) Male
- ( ) Female
- ( ) Other

Rank 8

Trade 8

Working status

- ( ) Off
- ( ) Part time
- ( ) Full time, modified duties
- (•) Full time, no restrictions

7. Medical Category

- ( ) None
- (•) TCAT
- ( ) PCAT

Numeric Pain Scale (NPS) for pain severity measurement

What has your average pain been over the last 7 days?

( )0	( )1	( )2	( )3	( )4	( )5	( )6	( )7	( )8	( )9	(•)10
None	**Mild**			**Moderate**			**Severe**			**Max**

What has your worst pain been over the last 7 days?

( )0	( )1	( )2	( )3	( )4	( )5	( )6	( )7	( )8	(•)9	( )10
None	**Mild**			**Moderate**			**Severe**			**Max**

What has your least pain been over the last 7 days?

( )0	( )1	( )2	( )3	( )4	( )5	( )6	( )7	(•)8	( )9	( )10
None	**Mild**			**Moderate**			**Severe**			**Max**

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Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of O means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

0	1	2	3	4	5	6	7	8	9	10
No Disability	**Mild**			**Moderate**			**Severe**			**Worst Disability**

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).										
○0	○1	○2	○3	○4	○5	○6	◉7	○8	○9	○10
Recreation: This disability includes hobbies, sports, and other similar leisure time activities.										
○0	○1	○2	○3	○4	○5	◉6	○7	○8	○9	○10
Social Activities: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.										
○0	○1	○2	○3	◉4	○5	○6	○7	○8	○9	○10
Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a stay at home parent or volunteer work.										
○0	○1	○2	◉3	○4	○5	○6	○7	○8	○9	○10
Sexual Behavior: This category refers to the frequency and quality of one's sex life.										
○0	○1	◉2	○3	○4	○5	○6	○7	○8	○9	○10
Self-care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.).										
○0	◉1	○2	○3	○4	○5	○6	○7	○8	○9	○10
Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.										
◉0	○1	○2	○3	○4	○5	○6	○7	○8	○9	○10

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Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often... Swear at you, insult you, put you down, or humiliate you? **OR** Act in a way that made you afraid that you might be physically hurt?	(●) Yes ( ) No
2. Did a parent or other adult in the household often ... Push, grab, slap, or throw something at you? **OR** Ever hit you so hard that you had marks or were injured?	( ) Yes (●) No
3. Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? **OR** Try to or actually have oral, anal, or vaginal sex with you?	(●) Yes ( ) No
4. Did you often feel that ... No one in your family loved you or thought you were important or special? **OR** Your family didn't look out for each other, feel close to each other, or support each other?	( ) Yes (●) No
5. Did you often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **OR** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	( ) Yes (●) No
6. Were your parents ever separated or divorced?	(●) Yes ( ) No
7. Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? **OR** Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? **OR** Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	( ) Yes (●) No
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	(●) Yes ( ) No
9. Was a household member depressed or mentally ill or did a household member attempt suicide?	( ) Yes (●) No
10. Did a household member go to prison?	(●) Yes ( ) No

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IEQ Injustice Experience Questionnaire When injuries happen, they can have profound effects on our lives. This scale was designed to assess how your injury has affected your life. Listed below are twelve statements describing different thoughts and feelings that you may experience when you think about your injury. Using the following scale, please indicate how frequently you experience these thoughts and feelings when you think about your injury.

Never	Rarely	Sometimes	Often	All the time
0	1	2	3	4

1. Most people don't understand how severe my condition is.				
○ 0	○ 1	○ 2	○ 3	◉ 4
2. My life will never be the same.				
○ 0	○ 1	○ 2	◉ 3	○ 4
3. I am suffering because of someone else's negligence				
○ 0	○ 1	◉ 2	○ 3	○ 4
4. No one should have to live this.				
○ 0	◉ 1	○ 2	○ 3	○ 4
5. I just want to have my life back.				
◉ 0	○ 1	○ 2	○ 3	○ 4
6. I feel that this has affected me in a permanent way.				
○ 0	◉ 1	○ 2	○ 3	○ 4
7. It all seems so unfair.				
○ 0	○ 1	◉ 2	○ 3	○ 4
8. I worry that my condition is not being taken seriously.				
○ 0	○ 1	○ 2	◉ 3	○ 4
9. Nothing will ever make up for all that I have gone through.				
○ 0	○ 1	○ 2	○ 3	◉ 4
10. I feel as if I have been robbed of something very precious.				
○ 0	○ 1	○ 2	◉ 3	○ 4
11. I am troubled by fears that I may never achieve my dreams.				
○ 0	○ 1	◉ 2	○ 3	○ 4
12. I can't believe that this has happened to me.				
○ 0	◉ 1	○ 2	○ 3	○ 4

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MLQ Meaning in Life Questionnaire: Please take a moment to think about what makes your life feel important to you. Please respond to the following statements as truthfully and accurately as you can, and also please remember that these are very subjective questions and that there are no right or wrong answers. Please answer according to the scale below:

Absolutely Untrue	**Mostly Untrue**	**Somewhat Untrue**	**Can't Say True or False**	**Somewhat True**	**Mostly True**	**Absolutely True**
1	2	3	4	5	6	7

1. I understand my life's meaning.						
◉ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
2. I am looking for something that makes my life feel meaningful.						
○ 1	◉ 2	○ 3	○ 4	○ 5	○ 6	○ 7
3. I am always looking to find my life's purpose.						
○ 1	○ 2	◉ 3	○ 4	○ 5	○ 6	○ 7
4. My life has a clear sense of purpose.						
○ 1	○ 2	○ 3	◉ 4	○ 5	○ 6	○ 7
5. I have a good sense of what makes my life meaningful.						
○ 1	○ 2	○ 3	○ 4	◉ 5	○ 6	○ 7
6. I have discovered a satisfying life purpose.						
○ 1	○ 2	○ 3	○ 4	○ 5	◉ 6	○ 7
7. I am always searching for something that makes my life feel significant.						
○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	◉ 7
8. I am seeking a purpose or mission for my life.						
○ 1	○ 2	○ 3	○ 4	○ 5	◉ 6	○ 7
9. My life has no clear purpose						
○ 1	○ 2	○ 3	○ 4	◉ 5	○ 6	○ 7
10. I am searching for meaning in my life						
○ 1	○ 2	○ 3	◉ 4	○ 5	○ 6	○ 7

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INTERNATIONAL PHYSICAL ACTIVITY QUESTIONNAIRE: We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives. The questions will ask you about the time you spent being physically active in the **last 7 days**. Please answer each question even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

Think about all the vigorous activities that you did in the last 7 days. Vigorous physical activities refer to activities that take hard physical effort and make you breathe much harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.	
1. During the last 7 days, on how many days did you do vigorous physical activities like heavy lifting, digging, aerobics, or fast bicycling?	7 days per week OR ● No vigorous physical activities *(Skip to question 3)*
2. How much time did you usually spend doing vigorous physical activities on one of those days?	6 hours per day 5 minutes per day ● Don't know/Not sure
Think about all the moderate activities that you did in the last 7 days. Moderate activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.	
3. During the last 7 days, on how many days did you do moderate physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking.	4 days per week OR ● No moderate physical activities *(Skip to question 5)*
4. How much time did you usually spend doing moderate physical activities on one of those days?	3 hours per day 2 minutes per day ● Don't know/Not sure
Think about the time you spent walking in the last 7 days. This includes at work and at home, walking to travel from place to place, and any other walking that you have done solely for recreation, sport, exercise, or leisure.	
5. During the last 7 days, on how many days did you walk for at least 10 minutes at a time?	1 days per week OR ● No walking ● *Skip to question 7*
6. How much time did you usually spend walking on one of those days?	9 hours per day 8 minutes per day ● Don't know/Not sure
The last question is about the time you spent sitting on weekdays during the last 7 days. Include time spent at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.	
7. During the last 7 days, how much time did you spend sitting on each day?	7 hours per day 6 minutes per day ● Don't know/Not sure

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PLEASE DO NOT FILL OUT

Data to be collected by Doctor - For Office Use Only

1. Type of Visit

- (●) Consultation
- ( ) Follow up

2. Pain Region(s) - Code

Region 1 aa

Region 2 bb

Region 3 cc

Region 4 dd

Region 5 ee

Region 6 ff

Other gg

3. Pain Diagnosis(s) - Code

Diagnosis 1 hh

Diagnosis 2 ii

Diagnosis 3 jj

Diagnosis 4 kk

Diagnosis 5 ll

Diagnosis 6 mm

Other nn

4. Mental Health Diagnosis(s) - Code

Diagnosis 1 oo

Diagnosis 2 pp

Diagnosis 3 qq

Diagnosis 4 rr

Diagnosis 5 ss

Diagnosis 6 tt

Other uu

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Coding System

Pain Region

1-Head
2-Neck
3-Shoulder (L/R/B)
4-Elbow (L/R/B)
5-Wrist (L/R/B)
6-Hand (L/R/B)
7-Thorax
8-Chest wall
9-Abdominal wall
10-Pelvis
11-Hip (L/R/B)
12-Thigh (L/R/B)
13-Knee (L/R/B)
14-Ankle (L/R/B)
15-Foot (L/R/B)
16-Low back
17-Body wide
18-Other:

Relevant Pain Diagnoses

1-Mechanical spinal pain
2-Mechanical joint pain
3-Radiculopathy
4-Tendinopathy
5-Osteoarthritis:
6-Adhesive Capsulitis
7-Headache
8-Brain injury
9-Polyneuropathy
10-Mononeuropathy,
11-Other CNS
12-Inflammatory disorder
13-CRPS
14-Exertional leg pain
15-Myofascial pain
16-Fibromyalgia
17-Fracture
18-Mechanical wall pain
19-Fasciopathy/ligamentopathy
20-Other:

Relevant Mental Health Diagnoses

1-Depression
2-PTSD
3-OSI
4-Pain Centralization
5-Adjustment Disorder
6-ADD/ADHD
7-Anxiety
8-OCD
9-Substance Abuse
10 Other: