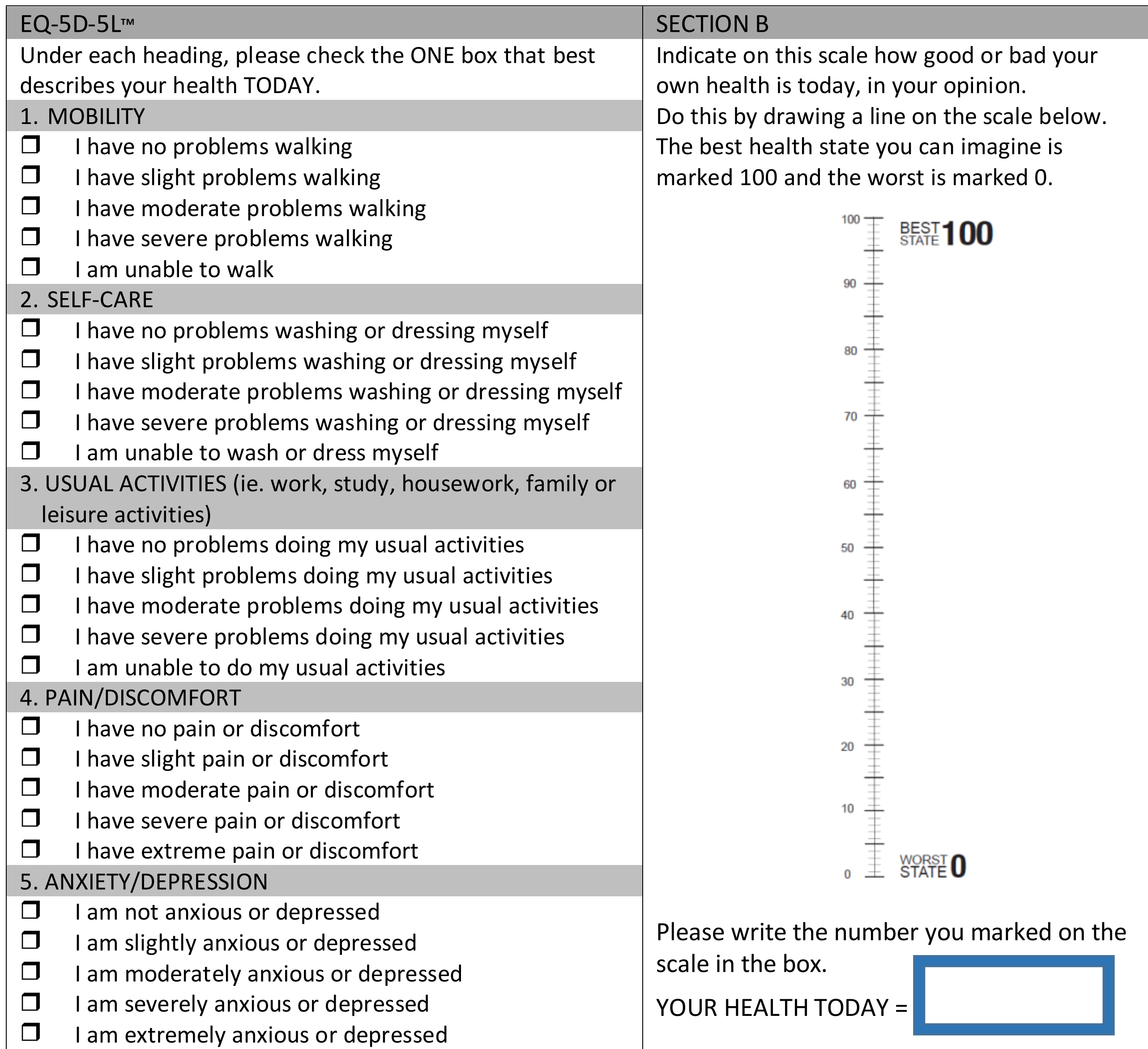
EQ-5D-5L

Under each heading, please tick the ONE box that best describes your health TODAY



EQ-5D-5L™

Under each heading, please check the ONE box that best describes your health TODAY.

1. MOBILITY

- ❐ I have no problems walking
- ❐ I have slight problems walking
- ❐ I have moderate problems walking
- ❐ I have severe problems walking
- ❐ I am unable to walk

2. SELF-CARE

- ❐ I have no problems washing or dressing myself
- ❐ I have slight problems washing or dressing myself
- ❐ I have moderate problems washing or dressing myself
- ❐ I have severe problems washing or dressing myself
- ❐ I am unable to wash or dress myself

3. USUAL ACTIVITIES (ie. work, study, housework, family or leisure activities)

- ❐ I have no problems doing my usual activities
- ❐ I have slight problems doing my usual activities
- ❐ I have moderate problems doing my usual activities
- ❐ I have severe problems doing my usual activities
- ❐ I am unable to do my usual activities

4. PAIN/DISCOMFORT

- ❐ I have no pain or discomfort
- ❐ I have slight pain or discomfort
- ❐ I have moderate pain or discomfort
- ❐ I have severe pain or discomfort
- ❐ I have extreme pain or discomfort

5. ANXIETY/DEPRESSION

- ❐ I am not anxious or depressed
- ❐ I am slightly anxious or depressed
- ❐ I am moderately anxious or depressed
- ❐ I am severely anxious or depressed
- ❐ I am extremely anxious or depressed

SECTION B

Indicate on this scale how good or bad your own health is today, in your opinion.
Do this by drawing a line on the scale below.
The best health state you can imagine is marked 100 and the worst is marked 0.

Please write the number you marked on the scale in the box.

YOUR HEALTH TODAY =

South Calgary Primary Care Network (SCPCN)
Brief Pain Inventory (Short Form)

June 2021
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Brief Pain Inventory © Copyright 1991 – Charles S. Cleeland, PhD Pain Research Group – All rights reserved.

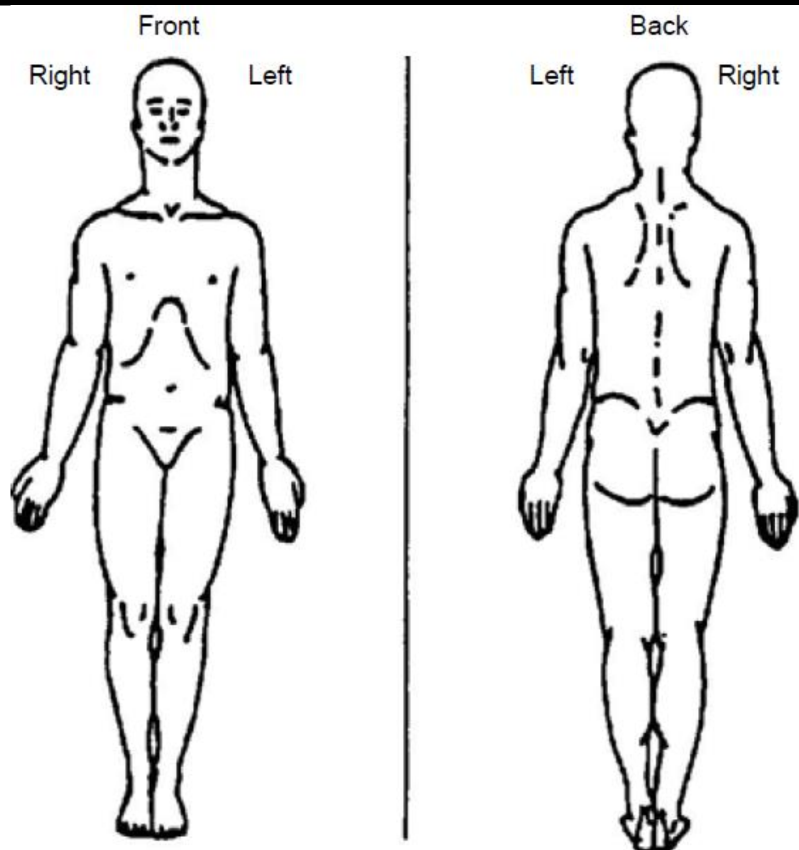
Date: ______________ **ID#:** ____________

Name: ______________ ______________ ______________
Last First Middle Initial

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

◯ Yes ◯ No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by selecting the one number that best describes your pain at its **worst** in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10	
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	Pain as bad as you can imagine
No Pain											

4. Please rate your pain by selecting the one number that best describes your pain at its **least** in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○
No Pain										Pain as bad as you can imagine

5. Please rate your pain by selecting the one number that best describes your pain on the **average**.

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○
No Pain										Pain as bad as you can imagine

6. Please rate your pain by selecting the one number that tells how much pain you have **right now**.

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○
No Pain										Pain as bad as you can imagine

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please select the one percentage that most shows how much **relief** you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
○	○	○	○	○	○	○	○	○	○	○
No Relief										Complete Relief

9. Select the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○
Does not Interfere										Completely Interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○
Does not Interfere										Completely Interferes

C. Walking Ability

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○
Does not Interfere										Completely Interferes

D. Normal Work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Does not Interfere										Completely Interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Does not Interfere										Completely Interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Does not Interfere										Completely Interferes

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Does not Interfere										Completely Interferes

Pain Catastrophizing Scale (Copyright 1995, 2001, 2004, 2006, 2009 Michael JL Sullivan, PhD)
Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feeling that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
I worry all the time about whether the pain will end	0	1	2	3	4
I feel I can't go on	0	1	2	3	4
It's terrible and I think it's never going to get any better	0	1	2	3	4
It's awful and I feel that it overwhelms me	0	1	2	3	4
I feel I can't stand it anymore	0	1	2	3	4
I become afraid that the pain will get worse	0	1	2	3	4
I keep thinking of other painful events	0	1	2	3	4
I anxiously want the pain to go away	0	1	2	3	4
I can't seem to keep it out of my mind	0	1	2	3	4
I keep thinking about how much it hurts	0	1	2	3	4
I keep thinking about how badly I want the pain to stop	0	1	2	3	4
There's nothing I can do to reduce the intensity of the pain	0	1	2	3	4
I wonder whether something serious may happen	0	1	2	3	4

Office Use Only:
MRN

Patient-Specific Functional Scale

Name: ______________________________ **Date:** ________________

Please read the following and complete.

Please identify **up to three important activities** that you are unable to do or are **having difficulty with** as a result of your current problem/diagnosis (i.e. the reason your doctor has referred you to therapy). Today, are there any activities that you are unable to do or having difficulty with because of your problem/diagnosis?

Please rate each of these problems on the 0-10 scale below.

0 = Able to perform activity at the same level as before injury or problem (No issues)

10 = Unable to perform activity (Cannot perform)

Patient-specific activity scoring scheme (Circle one number or provide a range):

1. Activity:

0	1	2	3	4	5	6	7	8	9	10
No Issues										**Cannot perform**

2. Activity:

0	1	2	3	4	5	6	7	8	9	10
No Issues										**Cannot perform**

3. Activity:

0	1	2	3	4	5	6	7	8	9	10
No Issues										**Cannot perform**