



Pain Concerns Form

Why have I been given this form?

- You have been given this form to help you and the clinical pharmacist talk about the concerns you have about your pain and the medicines you use for pain.
- It will help you both to focus on the things that are most important to you during your appointment.

What do I have to do?

- Before your appointment with the clinical pharmacist, please fill in this form and bring it with you to the appointment.
- Write your name and date of birth below.
- Read each statement and tick the box if you agree.

Name: _____ Date of birth ____ / ____ / ____

About my pain	Agree
My pain is not getting any better.	<input type="checkbox"/>
My pain is getting worse.	<input type="checkbox"/>
I don't understand why I still have pain.	<input type="checkbox"/>
My pain is not taken seriously.	<input type="checkbox"/>

PLEASE TURN OVER

Read each statement and tick the box if you agree.

Because of my pain...	Agree
I can't do my usual day-to-day activities e.g. housework, hobbies and social activities.	<input type="checkbox"/>
I can't continue in or return to work.	<input type="checkbox"/>
My pain stops me getting a good nights sleep.	<input type="checkbox"/>
I feel stressed, or I feel anxious.	<input type="checkbox"/>
My mood is low.	<input type="checkbox"/>
I feel frustrated or embarrassed that I can't do things.	<input type="checkbox"/>
I see my family and friends less than I used to.	<input type="checkbox"/>
I feel lonely and isolated.	<input type="checkbox"/>
I want to talk about the impact of my pain at my appointment	<input type="checkbox"/>

Regarding the medicines I take for pain...	Agree
I am concerned that these medicines do not help my pain enough.	<input type="checkbox"/>
I am concerned about how many medicines I take for pain.	<input type="checkbox"/>
I am concerned about the combination of medicines I take.	<input type="checkbox"/>
I am concerned about the short-term and/or long-term effects of my pain medicines.	<input type="checkbox"/>
I am concerned that my pain medicines will be stopped.	<input type="checkbox"/>

Other concerns relating to my pain or my pain management are...

THANK YOU FOR COMPLETING THIS FORM

PLEASE BRING IT ALONG TO YOUR APPOINTMENT WITH THE CLINICAL PHARMACIST