Global Burden of Pain Survey 2014

Please complete the survey below.

Thank you!

Country _____

District Name _____

Setting (e.g. home, school, community center) _____

GPS coordinate _____

Section A: Patient Background

Age

◯ < 18 ◯ 19 - 30 ◯ 31 - 50 ◯ > 50

Gender

◯ Male ◯ Female

How many people in your household?

◯ 1 ◯ 2 - 5 ◯ 6 - 10 ◯ > 10

Occupation

◯ Work in home (mother, homemaker)
◯ Industrial labor (factory work)
◯ Service (cook, clean, repair for others, etc)
◯ Merchant
◯ Driver
◯ Construction
◯ Agriculture
◯ Other

Please explain:

_____

Distance traveled to reach nearest clinic/hospital

◯ < 10 km ◯ 11 - 20 km ◯ 21 - 30 km ◯ 31 - 40 km ◯ > 40 km

Mode of transportation to clinic/household

◯ Walking
◯ Bicycle
◯ Bus
◯ Your own vehicle
◯ Borrowed vehicle
◯ Other

Other mode of transportation: _____

Method of payment for medical services (including meds)

◯ Cash
◯ Credit
◯ Government
◯ Barter / trade
◯ Private insurance
◯ Other

Other method of payment: _____

Section B: Patient Medical History

List of medical issues: Note all that apply

☐ Cancer
☐ TB or other infection
☐ Heart problem
☐ Diabetes
☐ Congenital deformity
☐ Intestinal problem
☐ Gynecologic problem
☐ Osteoarthritis
☐ Rheumatologic disease
☐ Neurologic disease
☐ Mental Health Issues - Please Describe when box is checked.
☐ Other

Mental Health Issues - Please describe:

_____

Other medical issues:

_____

If female, how many natural births? (Including live and stillborn) _____

If female, how many cesarean sections? _____

Section C: Patient Pain History

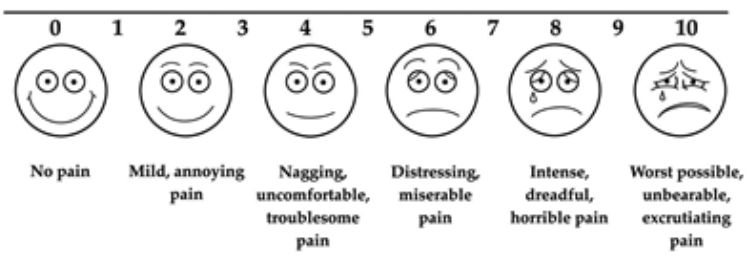
Do you have pain today?

◯ Yes ◯ No

If yes, rate the pain using the scale below:

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Pain Faces



Have you ever had pain every day that lasted for at least 6 months?

◯ Yes ◯ No

Do you have pain every day now?

◯ Yes ◯ No

If so, for how long have you had this type of chronic, daily pain?

◯ 0 - 6 months ◯ 7 months - 1 year ◯ > 1 year

If you have pain every day, is it always there or does it come and go?

◯ Always there ◯ Comes and goes

Did your pain start as a result of a specific accident, injury, trauma, or act of violence?

◯ Yes ◯ No

If so, what was this?

◯ Vehicle accident
◯ Injury while working
◯ Injury giving childbirth
◯ Injury at the time of your own birth
◯ War-related injury
◯ Burn
◯ Physical violence (assault)
◯ Sexual violence
◯ Other

Describe other:

_____

Section C: Patient Pain History continued

Is your pain because of a medical problem? (i.e. cancer, HIV)

◯ Yes ◯ No

If so, what is the problem?

☐ Cancer
☐ Congenital deformity
☐ Infectious disease (TB, AIDS, prostatitis etc)
☐ Rheumatic disorder (RA, lupus, Crohn's, etc)
☐ Organ problems (liver failure, kidney stones, uterine fibroids, hernias/intestinal issues, etc)
☐ Strokes or other brain or spinal cord diseases
☐ Osteoarthitis
☐ Diabetes
☐ Other

List other medical problem:

_____

If so, are you receiving treatment for this underlying medical problem?
(ie treatment specifically for the disease, not just for the pain)

◯ Yes ◯ No

Have you experienced anything you consider to be traumatic in your life?

◯ Yes ◯ No

Do you have nightmares or feel fearful or anxious related to this?

◯ Yes ◯ No

When I feel pain I think:

It's terrible and I feel it's never going to get any better. _____ (* Please record value based on scale shown above.)

I become afraid the pain will get worse. _____ (* Please record value based on scale shown above.)

I can't seem to keep it out of my mind. _____ (* Please record value based on scale shown above.)

I keep thinking about how badly I want the pain to stop. _____ (* Please record value based on scale shown above.)

Section C continued: Patient Pain History

Patient Pain History in the past 30 days, how much difficulty did you have in:

	None1	Mild2	Moderate3	Severe4	Extreme or cannot do5
Standing for long periods such as 30 minutes?	◯	◯	◯	◯	◯

	None1	Mild2	Moderate3	Severe4	Extreme or cannot do5
Taking care of your household responsibilities?	◯	◯	◯	◯	◯

	None1	Mild2	Moderate3	Severe4	Extreme or cannot do5
Learning a new task, for example learning how to get to a new place?	○	○	○	○	○

	None1	Mild2	Moderate3	Severe4	Extreme or cannot do5
How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	○	○	○	○	○

	None1	Mild2	Moderate3	Severe4	Extreme or cannot do5
How much have you been emotionally affected by your health problems?	○	○	○	○	○

	None1	Mild2	Moderate3	Severe4	Extreme or cannot do5
Concentrating on doing something for ten minutes?	○	○	○	○	○

	None1	Mild2	Moderate3	Severe4	Extreme or cannot do5
Walking a long distance such as a kilometra (or equivalent)?	○	○	○	○	○

	None1	Mild2	Moderate3	Severe4	Extreme or cannot do5
Washing your whole body?	○	○	○	○	○

	None1	Mild2	Moderate3	Severe4	Extreme or cannot do5
Getting dressed?	○	○	○	○	○

	None1	Mild2	Moderate3	Severe4	Extreme or cannot do5
Dealing with people you do not know?	○	○	○	○	○

	None1	Mild2	Moderate3	Severe4	Extreme or cannot do5
Maintaining a friendship?	○	○	○	○	○

	None1	Mild2	Moderate3	Severe4	Extreme or cannot do5
Your day-to-day work/school?	○	○	○	○	○

Overall, in the past 30 days, how many days were these difficulties present?

_____
(Record number of days.)

In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?

_____

In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition? _____

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 kinds of everyday pain today?

◯ Yes ◯ No

	None0	1	2	3	4	5	6	7	8	9	Pain as bad as you can imagine.10
Please rate your pain by selecting the one number that best describes your pain at its worst in the last 24 hours.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Please rate your pain by circling the one number that best describes your pain at its least in the last 24 hours.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Please rate your pain by circling the one number that best describes your pain on the average.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Please rate your pain by circling the one number that tells how much pain you have right now.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

During the last 24 hours, have you had any pain treatments or medications?

◯ Yes
◯ No

	No Relief0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	Complete relief100%
In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Click the one number that best describes how, during the last 24 hours, pain has interfered with your:

	Does not Interfere0	1	2	3	4	5	6	7	8	9	Completely Interferes10
General Activity	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Mood	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Walking Ability	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Normal Work	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Relations with other people	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Sleep	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Enjoyment of Life	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Section D: Access to Pain Treatment

If there was a pill to help your pain, would you take it?

◯ Yes ◯ No

How much would you pay per month (or single course)?

◯ < $5 ◯ $6 - $10 ◯ $11 - $20 ◯ $21 - $30 ◯ > $30

How far would you travel to get it?

◯ < 10 km ◯ 11 - 20 km ◯ 21 - 30 km ◯ 31 - 40 km ◯ > 40 km

Do you (or would you) feel comfortable talking about your pain with other people in your community?

◯ Yes ◯ No

Do you think the treatment of people's pain is important?

◯ Yes ◯ No

If there was an opportunity to participate in group treatment to teach you how to move and cope/live with pain more effectively, would you partcipate?

◯ Yes ◯ No

How far would you travel to do this?

◯ < 10 km ◯ 11 - 20 km ◯ 21 - 30 km ◯ 31 - 40 km ◯ > 40 km

Have you ever sought treatment for your pain?

◯ Yes ◯ No

Who gave the treatment? (may choose more than one)

- ☐ Physician
- ☐ Nurse
- ☐ Friend or family member
- ☐ Local healer
- ☐ Counselor or therapist
- ☐ Spiritual leader/clergy
- ☐ You gave to yourself
- ☐ Other:

Other:

_____

What was the treatment?

- ☐ Nothing
- ☐ Pill
- ☐ Acupuncture
- ☐ Herbal Therapy (Medicine from a plant)
- ☐ Movement based therapy (Stretching, Yoga)
- ☐ Mind based therapy (meditation, breathing, counselling)
- ☐ Procedure (Injection, surgery)
- ☐ Other

Other:

_____

How far did you travel to receive the treatment?

◯ < 10 km ◯ 11 - 20 km ◯ 21 - 30 km ◯ 31 - 40 km ◯ > 40 km

	Not effective1	2	3	4	Very Effective5
How effective was the tratment?	◯	◯	◯	◯	◯

Section E: Physical Pathology

Using the following scale, indicate for each item your severity over the past week by clicking the appropriate button.

0: No problem
1: Slight or mild problems; generally mild or intermittent
2: Moderate; considerable problems; often present and/or at moderate level
3: Severe: continuous, life-disturbing problems

	0	1	2	3
Fatigue	◯	◯	◯	◯
Trouble thinking or remembering	◯	◯	◯	◯
Waking up tired (unrefreshed)	◯	◯	◯	◯

During the past 6 months have you had any of the following symptoms?

Pain or cramps in lower abdomen:

◯ Yes ◯ No

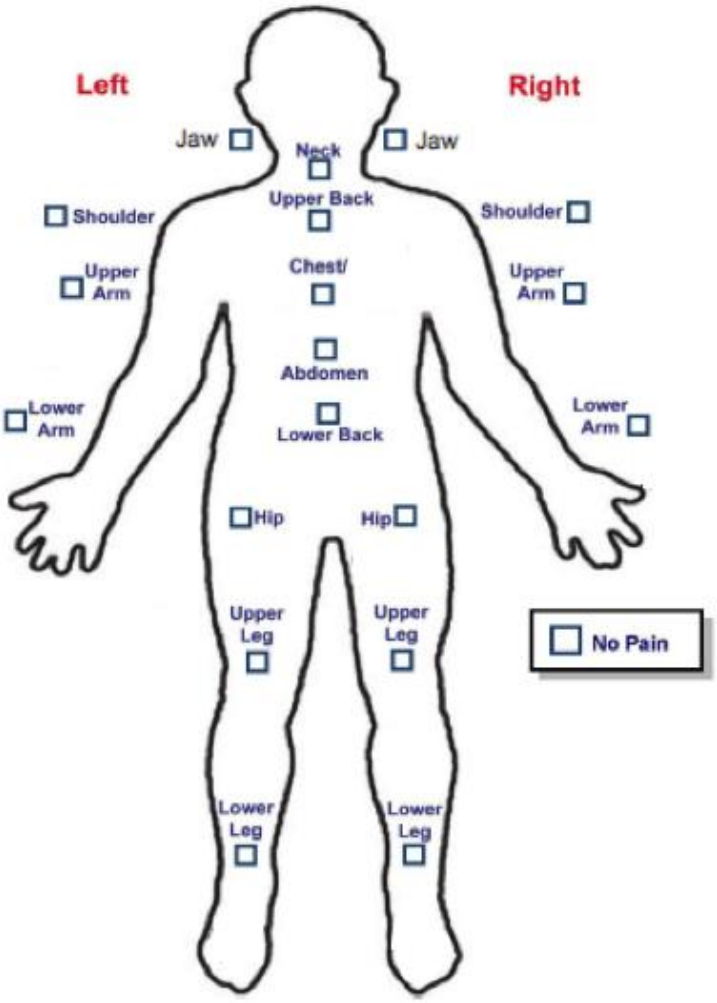
Depression:

◯ Yes ◯ No

Headache:

◯ Yes ◯ No

Check below each area where you have had pain for at least 3 months.



Check all that apply:

☐ No Pain ☐ Left Jaw ☐ Neck ☐ Right Jaw ☐ Left Shoulder ☐ Upper Back ☐ Right Shoulder
☐ Left Upper Arm ☐ Chest ☐ Right Upper Arm ☐ Left Lower Arm ☐ Abdomen ☐ Right Lower Arm
☐ Lower Back ☐ Left Hip ☐ Right Hip ☐ Left Upper Leg ☐ Right Upper Leg ☐ Left Lower Leg
☐ Right Lower Leg