PARENT/CARER REFERRAL QUESTIONNAIRE

Section 1 – Parent/Carer details

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss	**Family name** *(surname)*	**Given name(s)**
Gender ☐ Male ☐ Female	**Postcode**	**Today's date** *(dd/mm/yyyy)* __ __ /__ __ / __ __ __ __
Email address		
Relationship to child: ☐ Parent/Step-parent ☐ Relative *(e.g. grandparent, kinship carer)* ☐ Foster carer ☐ Other		
Do you require help with written or spoken communication? ☐ Yes ☐ No		

Section 2 – Information about your child

Family name *(surname)*	**Given name(s)**	**Gender** ☐ Male ☐ Female
Date of birth *(dd/mm/yyyy)* __ __ /__ __ /__ __ __ __	**Height** *(in cm)*	**Weight** *(in kg)*
Country of birth ☐ Australia ☐ New Zealand ☐ Other (please specify) ……..		
Is your child of Aboriginal or Torres Strait Islander origin? *(more than one may be ticked)* ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander		
What is your child's current level of school? ☐ Preschool ☐ Primary school ☐ Secondary school ☐ Other		
How did your child's main pain begin? *(please select **one** box only)* ☐ Injury ☐ After surgery ☐ Illness ☐ No known cause ☐ Other ……		
How long has your child's main pain been present? *(Tick **one** box only)* ☐ Less than 3 months ☐ 3 to 12 months ☐ More than 12 months		
Is there a current or potential legal case relating to your child's pain problem? *(e.g. compensation/public liability claim)* ☐ Yes ☐ No		
Has your child previously attended a specialist pain service at a children's hospital? ☐ Yes ☐ No		

Does your child have any of the following health conditions?

☐ A chronic disease (e.g. arthritis, inflammatory bowel disease, rare disease of childhood)

☐ A mental health condition (e.g. depression, anxiety, eating disorder, ADHD)

☐ Cancer, now or in the past

Does your child have any of the following pre-existing disabilities?

☐ Sight impairment

☐ Hearing impairment

☐ Intellectual disability

☐ Physical disability

Please provide further details about your child's health conditions and disabilities

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Was your child able to complete his or her questionnaire? ☐ Yes ☐ No

If no, please specify the reason:

☐ Refused

☐ Too young

☐ Cognitively unable to complete

☐ Non-English speaking

☐ Physically unable to complete

☐ Other *(please specify)* .....

Section 3 – Your child's pain

Which statement best describes your child's pain? *(tick **one** box only)*

☐ Always present (always the same intensity)

☐ Always present (intensity varies)

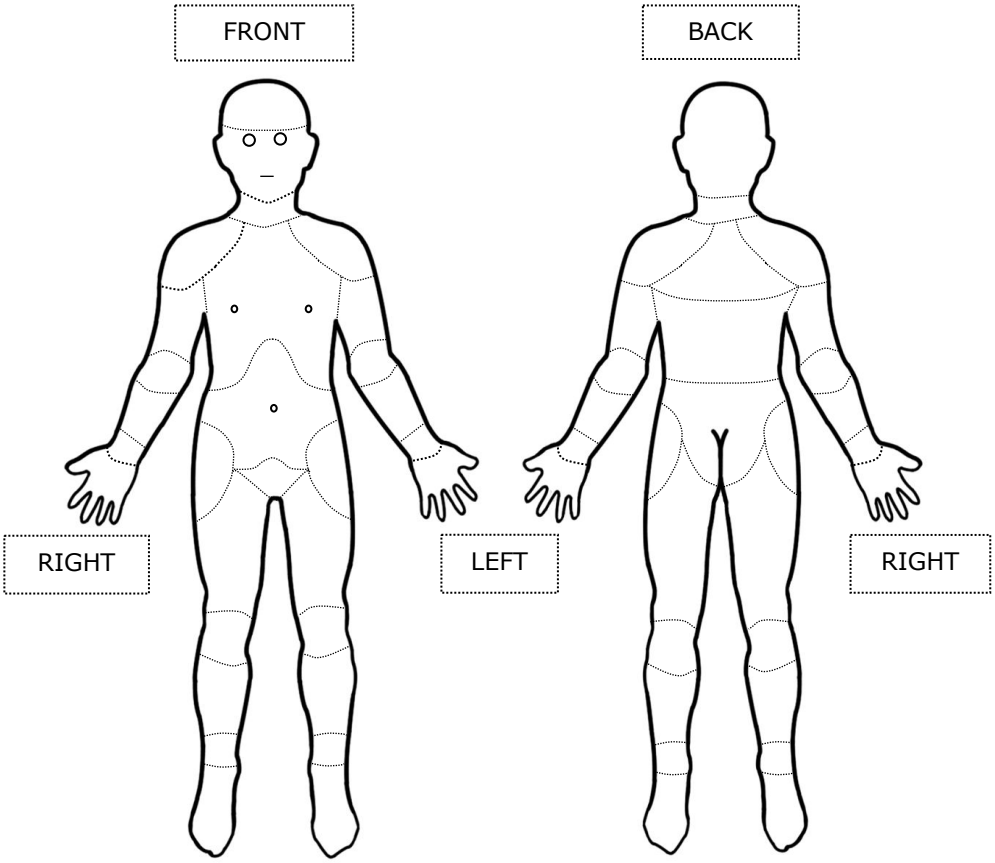
☐ Often present (pain free periods last less than 6 hours)

☐ Occasionally present (pain occurs once to several times per day, lasting up to an hour)

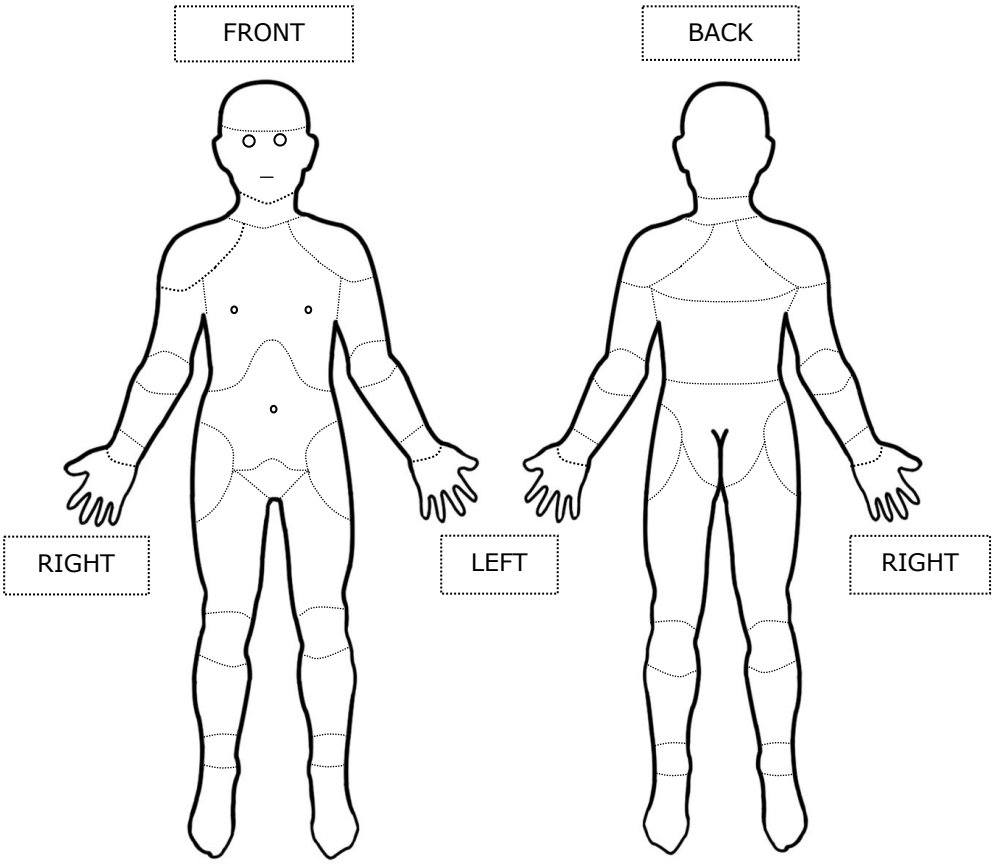
☐ Rarely present (pain occurs every few days or weeks)

How many school days has your child missed in the previous <u>two weeks</u> because of pain? *(include whole and part days missed because of pain and/or pain-related appointments/treatment)* ..... days

On the diagram below, shade in ALL the areas where your child feels pain



On the diagram below, put an X on the ONE area that hurts most for your child



Please rate your child's pain by circling the ONE number that best describes the following:											
1. Your child's pain at its **worst** in the last week?	0	1	2	3	4	5	6	7	8	9	10
	No pain										Pain as bad as you can imagine
2. Your child's pain at its **least** in the last week?	0	1	2	3	4	5	6	7	8	9	10
	No pain										Pain as bad as you can imagine
3. Your child's pain on **average**?	0	1	2	3	4	5	6	7	8	9	10
	No pain										Pain as bad as you can imagine
4. How much pain your child has **right now**?	0	1	2	3	4	5	6	7	8	9	10
	No pain										Pain as bad as you can imagine

Section 4 – Health care *(other than your child's visits to the pain clinic)*

1. How many times in the **past 3 months** has your child seen a general practitioner in regard to pain? ..... times
2. How many times in the **past 3 months** has your child seen a medical specialist (e.g. paediatrician, surgeon) in regard to pain? ..... times
3. How many times in the **past 3 months** has your child seen health professionals other than doctors (e.g. physiotherapist, psychologist) in regard to pain? ..... times
4. How many times in the **past 3 months** has your child seen other therapists (e.g. naturopath, chiropractor) in regard to pain? ..... times
5. How many times in the **past 3 months** has your child visited a hospital emergency department in regard to pain? *(Include all visits, regardless of whether or not your child was admitted to the hospital from the emergency department)* ..... times
6. How many times in the **past 3 months** has your child been admitted to hospital as an inpatient because of pain? ..... times
7. How many diagnostic tests (e.g. X-rays, scans) has your child had in the **last 3 months** relating to their pain? ..... tests

Section 5 – Medication use					
How often has your child used any of the following medicines for pain in the **last month**?	Daily	Often	Some-times	Rarely	Never
Paracetamol-only medicines e.g. Panadol®, Panamax®, Panadol® Osteo, Paracetamol suspension	☐	☐	☐	☐	☐
Anti-inflammatory medicines *purchased without a prescription* e.g. Ibuprofen, Nurofen®, Naprogesic®, Naprosyn®, Voltaren®	☐	☐	☐	☐	☐
Anti-inflammatory medicines *needing a prescription* e.g. Celebrex®, Celecoxib capsules	☐	☐	☐	☐	☐
Complementary or alternative medicines e.g. herbal or homeopathic medicines, non-prescribed vitamins, fish oil	☐	☐	☐	☐	☐
Opioid medicines containing Codeine e.g. Panadeine®, Pain Stop®, Nurofen Plus®, Mersyndol®, Panadeine Forte®, Codalgin Forte®	☐	☐	☐	☐	☐
Opioid medicines *other than Codeine* e.g. Morphine, Oxycodone, Endone®	☐	☐	☐	☐	☐
Medication for nerve pain e.g. Amitriptyline, Endep®, Nortriptyline, Gabapentin, Pregabalin, Neurontin®, Lyrica®	☐	☐	☐	☐	☐

Please continue to the next page

We acknowledge the use of the following questions and assessment tools

- Pain Chart: Childhood Arthritis and Rheumatology Research Alliance, www.carragroup.org von Baeyer CL et al, Pain Management, 2011;1(1):61-68
- Modified Brief Pain Inventory questions, reproduced with acknowledgement of the Pain Research Group, the University of Texas MD Anderson Cancer Centre
- Work productivity questions from the Work Productivity and Activity Impairment Questionnaire, Reilly MC, Zbrozek AS & Dukes EM (1993)
- PedsQL, Copyright© 1998 JW Varni, Ph.D

Section 6 – Parent/Carer Work

Are you currently employed (working for pay)?

☐ Yes - If *yes*, are you:

- ☐ Working full-time
- ☐ Working part-time

Please answer the questions below

☐ No - If *no*, are you:

*(tick **one** only, then go straight to the next page)*

- ☐ Unable to work due to reasons associated with your child's pain
- ☐ Not working by choice (student, retired, homemaker)
- ☐ Seeking employment (I consider myself able to work but cannot find a job)

During the past seven days, how many hours did you miss from work because of problems <u>associated with your child's pain</u>?

(Include hours you missed on sick days, times you went in late, left early, etc. because of your child's pain. Do not include time you missed to attend this pain clinic.)

..... hours

During the past seven days, how many hours did you actually work? *(If '0' skip the next question and go to the next page)*

..... hours

During the past seven days, how much did your child's pain affect your productivity <u>while you were working</u>?

Think about days you were limited in the amount or kind of work you could do, days you accomplished less than you would like, or days you could not do your work as carefully as usual.

If your child's pain affected your work only a little, choose a low number.
Choose a high number if your child's pain affected your work a great deal.

Consider only how much your <u>child's pain</u> affected your productivity <u>while you were working</u>

My child's pain had no effect on my work	0	1	2	3	4	5	6	7	8	9	10	My child's pain completely prevented me from working

CIRCLE A NUMBER