

MOM-20 Questionnaire

TODAY'S DATE/...../.....

SURNAME FIRST NAME D.O.B. / /

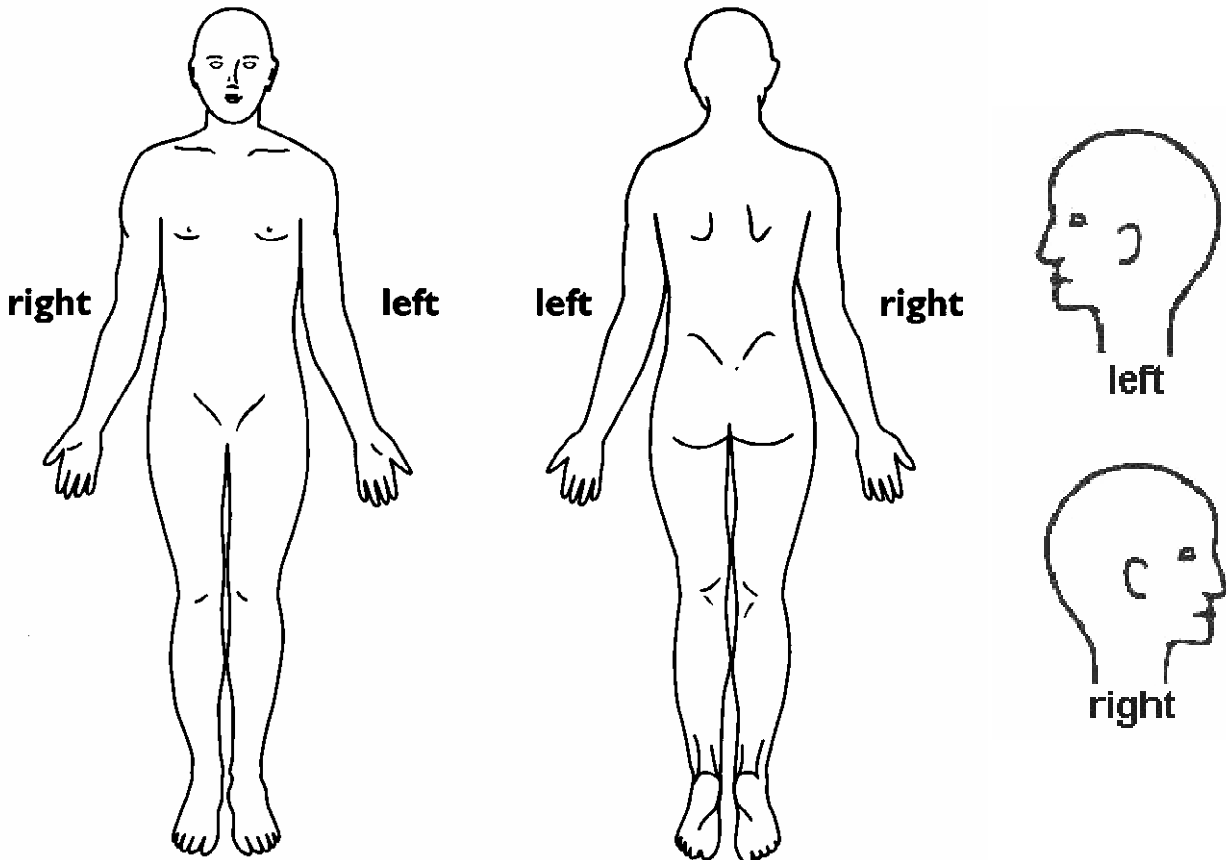
Q1. Please rate your pain on the scale below from 0 to 10. Please circle one number that best fits your average level of pain in the last week. For example very mild pain = 1, severe pain = 8.

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable
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Q2. Please circle those words below that fit the description of your pain:

shooting stabbing sharp cramping gnawing hot/burning
 throbbing aching pulling dull heavy tender tight splitting
 tiring-exhausting sickening fearful punishing cruel terrifying nauseating agonizing

Q3. Mark all the areas on your body where you feel pain or abnormal sensations. Please include all areas of pain even though you may feel they may not be relevant to your current problem.



Now please turn over and answer a few more questions to help us assess your condition

For the following questions circle the number that best fits how you are affected by your pain / condition.

4. During **the past week** to what extent have you

	Not at all	Mildly	Moderately	Very much	Totally Constantly
a) Needed to lie down during the day	0	1	2	3	4
b) Felt downhearted and sad	0	1	2	3	4
c) Felt nervous and uptight	0	1	2	3	4
d) Felt tired and lacking in energy	0	1	2	3	4
e) Had trouble sleeping	0	1	2	3	4
f) Had headaches	0	1	2	3	4
g) Felt dizziness	0	1	2	3	4

5. During **the past week** how difficult was it (or would it have been) for you to do the following activities:

	No trouble	A bit difficult	Moderately difficult	Very difficult	Can't do at all
a) Your normal work (including both work outside the home and housework)	0	1	2	3	4
b) Your normal social activities	0	1	2	3	4
c) Your usual sport and recreation	0	1	2	3	4
d) Getting dressed, bathing and personal hygiene	0	1	2	3	4
e) Usual sexual activity - (optional)	0	1	2	3	4

For the following questions tick a box that matches your answer best.

6. How confident are you that you can do most things (live a normal lifestyle) despite your pain?

- Not at all A little Moderately Quite a lot Extremely Completely

7. Over the course of treatment for your pain, how satisfied were you with your overall medical care?

- Very dissatisfied Somewhat dissatisfied Neither satisfied nor dissatisfied Somewhat satisfied Very satisfied

8. During the **past 4 weeks**, how many times did you attend a doctor or other health care giver in relation to your pain? Mark the total number of visits to all practitioners.

- 0 once 2-3 times 4-5 times 6-7 times 8 or more

9. Medication: During the **past week**, on average how many tablets for pain have you taken per day:

- Nil Occasional 1-2 per day 3-5 per day 6-8 per day more than 8

The end

For your doctor to answer: 10. What type of medication is taken:

- Nil Simple Analg Compound An Compound An + Psych Strong Opioid

For office use only:	P	/ 10	Ps	/ 20	Meds	/ 20	Dis	/100
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