# Trinity Behavioral Health

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## CONSENT TO EVALUATION & TREATMENT

This form is used to acquire informed consent to receive psychological services (i.e. evaluation and treatment). By signing this form I understand I am hereby giving my consent to participate in the evaluation process and any prescribed psychological treatment services (e.g. psychotherapy and biofeedback) as needed. I also acknowledge that I am receiving these services under my own free will and that I understand I can withdraw my consent and discontinue my participation at any time.

Therapy can help a person to gain new understanding about his or her problems and to learn new ways of coping with and solving those problems, such as anxiety, anger, depression, parenting or relationship concerns. Therapy can help a person to develop new skills and to change behavior patterns. Therapy can contribute to improved ability to cope with stress and difficult situations and can increase understanding of self and others.

I acknowledge that Dr. Young has advised me that while there are potential benefits to therapy, there is no guarantee of success and that there are potential risks. I have been advised that during therapy emotions and memories may be stimulated which can evoke strong feelings and that changes in awareness may alter my self-perceptions and ways of relating to others. I have been advised that the process of personal change can be quite varied and individual. I understand that it is important that I mention promptly any concerns or questions to Dr. Young that I may have at any time during the process of therapy.

I have been advised by Dr. Young that all communications with me and all records relating to the provision of psychological services to me are confidential and may not be disclosed without my written consent. I also am aware, and by signing this form give my consent for Dr. Young to release copies of any evaluation reports and treatment notes as needed to third party payers (i.e. insurance carriers) in order to be reimbursed for providing psychological services. I also have been advised by Dr. Young the law places certain limits on the confidential nature of the psychological services provided to me. I have been advised that these limits on confidentiality may arise if Dr. Young perceives that there is risk of harm in situations such as the following: 1) if I present an imminent danger to myself or others the law requires that steps be taken to prevent such harm; 2) if a child is in need of protection a report must be filed with the appropriate agency or authority; 3) if a vulnerable adult is abused or neglected a report may be filed with the appropriate government agency; 4) or if a court orders the disclosure of records

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As a courtesy to each patient, this office will file your insurance for you for reimbursement. In order to accomplish this, you as the patient agree to allow this office to release any personal identifying information (e.g. social security number, address etc.) necessary to the insurance carrier in order to facilitate payment. You also recognize that unless you are covered under a worker's compensation claim, any information provided from this office in order to facilitate billing and reimbursement will not include treatment records (e.g. progress notes or reports). If you are covered under a workers' compensation claim, then treatment records must be forwarded along with each reimbursement claim pursuant to federal and state law.

It also is understood and agreed that should it be necessary for this office to hire an attorney or collection agency to collect the account, the patient agrees to pay fees and all costs of collection. The patient also agrees to and understands that any account sent to collections will necessitate the release of personal identifying information, such as social security number, address etc, in order to facilitate the collection process.

I acknowledge that I have had the opportunity to carefully read this document and to ask, and have answered, any questions or concerns I have about it or arising from it. I further acknowledge that I have read and understood the information contained in this document and that it records my consent and I am aware I can receive a copy of it upon request.

Signed:

Patient Name: _____

Patient Signature: _____ Date: _____

Chronic Pain • Mood Disorders • Marriage & Family
Medical & Forensic Evaluations • Gifted & Learning Disability Assessments
Adults • Adolescents • Couples

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**PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND SIGN:**

**Cancellation / No-Show Policy:**

When a patient makes a late appointment cancellation, it is impossible for our office to schedule another patient in that time slot, resulting in a loss of revenue. Because of this, it is necessary to assess a **$100 fee** for any cancellations not completed within 24-hours of the scheduled appointment. All **no-show appointments** are automatically assessed the **$100 fee**. There are no exceptions to the no-show policy. No-show appointments will always be assessed the $100 no-show fee.

**Credit Card / Debit Card Processing**

When you use a credit card or debit card the charge will be under Trinity Behavioral Health. Additionally, there will be a 4% additional fee added to the amount due to cover the fee for processing the credit card charge.

**Financial Responsibility**

Due to high cost of health care, payment is due at time of service. As a courtesy to each patient, your insurance company will be billed directly. Should your insurance company deny or make only a partial payment, the patient WILL be responsible for the balance due. Please also note, it is understood and agreed that should it be necessary to hire an attorney or collection agency to collect on a patient's account, the patient agrees to pays all fees and costs of collection, to include those of an attorney if one is necessary.

Thank you for your understanding.

Robert W. Young, Ph.D.

_____ _____

Patient Signature Date

Chronic Pain • Mood Disorders • Marriage & Family
Medical & Forensic Evaluations • Gifted & Learning Disability *Assessments*
Adults • Adolescents • Couples

# Pain Outcomes Questionnaire (POQ): Intake

Michael E. Clark, Ph.D., Ronald J. Gironda, Ph.D., and
The American Academy of Pain Management

**Patient:** _____ **Social Security #:**_____

1.) Enter today's date: ____ / ____ / ____ (MM/DD/YY)

2.) What is your age? _____

3.) Please indicate your sex:

A) male B) female

4.) Please indicate your race:

A) African American
B) White
C) Hispanic
D) Asian
E) American Indian
F) Other

5.) What is your current marital status?

A) never married
B) married
C) living with someone but not married
D) divorced or separated
E) widowed

6.) What is your current employment status?

A) full-time employment
B) part-time employment
C) unemployed, not interested in returning to work
D) unemployed, looking for work
E) unemployed, disabled
F) retired due to pain
G) retired not due to pain

7.) How many years of education have you completed starting with the first grade?
_____ Years

8.) Please select all of the following types of claims you have filed related to your pain problem:
A) workers' compensation
B) personal injury (unrelated to work)
C) Social Security Disability Insurance (SSDI)
D) other insurance
E) none

9.) Are you currently involved in a formal legal suit related to your pain problem?

A) yes B) no

10.) Please select all of the following pain locations that apply to you:

| | | | | |
|---|---|---|---|---|
| A) leg | E) head | I) foot | M) arm/hand | Q) genitals |
| B) low back | F) neck | J) jaw | N) fingers | R) other |
| C) mid-back | G) shoulder | K) chest | O) toes | |
| D) upper back | H) buttocks | L) abdomen | P) face | |

11.) From the above pain sites, pick the **ONE** pain location that most interferes with your life:

| | | | | |
|---|---|---|---|---|
| A) leg | E) head | I) foot | M) arm/hand | Q) genitals |
| B) low back | F) neck | J) jaw | N) fingers | R) other |
| C) mid-back | G) shoulder | K) chest | O) toes | |
| D) upper back | H) buttocks | L) abdomen | P) face | |

11a.) Please select the adjectives below that best describe the quality of your primary pain.

___ Aching ___ Pinching ___ Sharp ___ Tender ___ Throbbing ___ Tightness
___ Dull ___ Pressure ___ Shooting ___ Soreness ___ Stabbing ___ Burning
___ Heaviness ___ Numbness ___ Pricking ___ Pulling ___ Pins & Needles

12.) On a scale of 0 to 10, with 0 being no pain at all and 10 being the worst possible pain, how would you rate your pain on the **AVERAGE** during the **LAST WEEK**?

0 1 2 3 4 5 6 7 8 9 10
no pain at all — worst possible pain

13.) Using the same 0 to 10 rating scale, please rate what your **ACCEPTABLE** average level of pain would be:

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| no pain at all | | | | | | | | | | worst possible pain |

14.) How long have you had the pain for which you are now seeking treatment?

_____ Years _____ Months

15.) Approximately how many health care visits have you had in the **LAST 3 MONTHS** for your **CURRENT PAIN PROBLEM**? Include **ALL** visits to any health care provider. For example, if you saw a surgeon once, a physical therapist 12 times, and a chiropractor 2 times for reasons related to your pain, the total number of visits would be 15.

Number of health care visits: _____

16.) Please indicate any other physical illnesses or conditions you may have other than pain (indicate all that apply):

| | | | |
|---|---|---|---|
| A) diabetes | D) heart disease | G) thyroid disease | J) other |
| B) lung disease | E) high blood pressure | H) liver disease | K) none |
| C) kidney disease | F) cancer | I ) seizures | |

17.) Does your pain interfere with your ability to walk?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| not at all | | | | | | | | | | all the time |

18.) Does your pain interfere with your ability to carry/handle everyday objects such as a bag of groceries or books?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| not at all | | | | | | | | | | all the time |

19.) Does your pain interfere with your ability to climb stairs?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| not at all | | | | | | | | | | all the time |

20.) Does your pain require you to use a cane, walker, wheelchair or other devices?

0 1 2 3 4 5 6 7 8 9 10
not at all — all the time

21.) Does your pain interfere with your ability to bathe yourself?

0 1 2 3 4 5 6 7 8 9 10
not at all — all the time

22.) Does your pain interfere with your ability to dress yourself?

0 1 2 3 4 5 6 7 8 9 10
not at all — all the time

23.) Does your pain interfere with your ability to use the bathroom?

0 1 2 3 4 5 6 7 8 9 10
not at all — all the time

24.) Does your pain interfere with your ability to manage your personal grooming (for example, combing your hair, brushing your teeth, etc.)?

0 1 2 3 4 5 6 7 8 9 10
not at all — all the time

25.) Does your pain affect your self-esteem or self-worth?

0 1 2 3 4 5 6 7 8 9 10
not at all — all the time

26.) How would you rate your physical activity?

0 1 2 3 4 5 6 7 8 9 10
significant limitation in basic activities — can perform vigorous activities without limitation

27.) How would you rate your overall energy?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| totally worn out | | | | | | | | | | most energy ever |

28.) How would you rate your strength and endurance **TODAY**?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| very poor strength and endurance | | | | | | | | | | very high strength and endurance |

29.) How would you rate your feelings of depression **TODAY**?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| not depressed at all | | | | | | | | | | extremely depressed |

30.) How would you rate your feelings of anxiety **TODAY**?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| not anxious at all | | | | | | | | | | extremely anxious |

31.) How much do you worry about re-injuring yourself if you are more active?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| not at all | | | | | | | | | | all the time |

32.) How safe do you think it is for you to exercise?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| not safe at all | | | | | | | | | | extremely safe |

33.)Do you have problems concentrating on things **TODAY?**

0 1 2 3 4 5 6 7 8 9 10
not at all all the time

34.)How often do you feel tense?

0 1 2 3 4 5 6 7 8 9 10
not at all all the time

35.)Do you have a disability claim of **ANY** type currently pending?

A) yes B) no

36.)Are you currently taking any narcotic medications **ON A DAILY BASIS** (for example, codeine, Darvon, Demerol, Dilaudid, Duragesic, MS Contin, Percocet, Vicodin, Lortab, Oramorph, Tylenol #3 or #4, etc.)?

A) yes B) no

If you answered **YES** to question #36, **COMPLETE QUESTIONS #37 & #38 ONLY.**

If you answered **NO** to question #36, **SKIP TO QUESTION #39**

37.)How long have you been using narcotic medication **ON A DAILY BASIS** for your pain problem?

_____ Years _____ Months

38.)Please rate the degree of pain relief you currently receive from these medications:

0 1 2 3 4 5 6 7 8 9 10
no relief complete relief

**STOP HERE** (If you answered **YES** to question #36)

(continue to BDI-II)

39.)Have you taken narcotic medications **ON A DAILY BASIS DURING ANY PERIOD OF TIME** (for example, codeine, Darvon, Demerol, Dilaudid, Duragesic, MS Contin, Percocet, Vicodin, Lortab, Oramorph, Tylenol #3 or #4, etc.)?

A) yes B) no

If you answered **YES** to question #39, **PLEASE CONTINUE.**

If you answered **NO** to question #39, **STOP HERE.**

40.)How long has it been since you last used narcotic medication **ON A DAILY BASIS?**

_____ Years _____ Months

41.)How long did you use narcotic medication **ON A DAILY BASIS** for your pain problem?

_____ Years _____ Months

42.)Please rate the degree of pain relief you received from these medications:

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| no relief | | | | | | | | | | complete relief |

# BDI-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

**Instructions:** This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

**1. Sadness**

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

**2. Pessimism**

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

**3. Past Failure**

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

**4. Loss of Pleasure**

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

**5. Guilty Feelings**

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

**6. Punishment Feelings**

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

**7. Self-Dislike**

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

**8. Self-Criticalness**

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

**9. Suicidal Thoughts or Wishes**

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

**10. Crying**

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

_____ Subtotal Page 1

Continued on Back

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**11. Agitation**

0 I am no more restless or wound up than usual.

1 I feel more restless or wound up than usual.

2 I am so restless or agitated that it's hard to stay still.

3 I am so restless or agitated that I have to keep moving or doing something.

**12. Loss of Interest**

0 I have not lost interest in other people or activities.

1 I am less interested in other people or things than before.

2 I have lost most of my interest in other people or things.

3 It's hard to get interested in anything.

**13. Indecisiveness**

0 I make decisions about as well as ever.

1 I find it more difficult to make decisions than usual.

2 I have much greater difficulty in making decisions than I used to.

3 I have trouble making any decisions.

**14. Worthlessness**

0 I do not feel I am worthless.

1 I don't consider myself as worthwhile and useful as I used to.

2 I feel more worthless as compared to other people.

3 I feel utterly worthless.

**15. Loss of Energy**

0 I have as much energy as ever.

1 I have less energy than I used to have.

2 I don't have enough energy to do very much.

3 I don't have enough energy to do anything.

**16. Changes in Sleeping Pattern**

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.

1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.

2b I sleep a lot less than usual.

3a I sleep most of the day.

3b I wake up 1–2 hours early and can't get back to sleep.

**17. Irritability**

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

**18. Changes in Appetite**

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.

1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.

2b My appetite is much greater than usual.

3a I have no appetite at all.

3b I crave food all the time.

**19. Concentration Difficulty**

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

**20. Tiredness or Fatigue**

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily than usual.

2 I am too tired or fatigued to do a lot of the things I used to do.

3 I am too tired or fatigued to do most of the things I used to do.

**21. Loss of Interest in Sex**

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

12 ABCDE



_____ Subtotal Page 2

_____ Subtotal Page 1

_____ Total Score

BAI®

NAME _____ DATE _____

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

| | NOT AT ALL | MILDLY (It did not bother me much) | Moderately (It was very unpleasant but I could Stand it) | SEVERELY (I could Barely Stand it) |
|---|---|---|---|---|
| 1. Numbness or tingling. | 1. | | | |
| 2. Feeling hot. | 2. | | | |
| 3. Wobbliness in legs. | 3. | | | |
| 4. Unable to relax. | 4. | | | |
| 5. Fear of the worst happening. | 5. | | | |
| 6. Dizzy or lightheaded. | 6. | | | |
| 7. Heart pounding or racing. | 7. | | | |
| 8. Unsteady. | 8. | | | |
| 9. Terrified. | 9. | | | |
| 10. Nervous. | 10. | | | |
| 11. Feelings of choking. | 11. | | | |
| 12. Hands trembling. | 12. | | | |
| 13. Shaky. | 13. | | | |
| 14. Fear of losing control. | 14. | | | |
| 15. Difficulty breathing. | 15. | | | |
| 16. Fear of dying. | 16. | | | |
| 17. Scared. | 17. | | | |
| 18. Indigestion or discomfort in abdomen | 18. | | | |
| 19. Faint. | 19. | | | |
| 20. Face flushed. | 20. | | | |
| 21. Sweating (not due to heat). | 21. | | | |

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9 8 7 6 5 4 3 2 1 A B C D E

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APPENDIX C

# Dysfunctional Attitude Scale–24 Items (DAS-24)

| Attitudes | Totally Agree | Agree Very Much | Agree Slightly | Neutral | Disagree Slightly | Disagree Very Much | Totally Disagree |
|---|---|---|---|---|---|---|---|
| 1. If I fail partly, it is as bad as being a complete failure. | | | | | | | |
| 2. If others dislike you, you cannot be happy. | | | | | | | |
| 3. I should be happy all the time. | | | | | | | |
| 4. People will probably think less of me if I make a mistake. | | | | | | | |
| 5. My happiness depends more on other people than it does on me. | | | | | | | |
| 6. I should always have complete control over my feelings. | | | | | | | |
| 7. My life is wasted unless I am a success. | | | | | | | |
| 8. What other people think about me is very important. | | | | | | | |
| 9. I ought to be able to solve my problems quickly and without a great deal of effort. | | | | | | | |
| 10. If I don't set the highest standards for myself, I am likely to end up a second-rate person. | | | | | | | |
| 11. I am nothing if a person I love doesn't love me. | | | | | | | |
| 12. A person should be able to control what happens to him. | | | | | | | |

*(continued)*

APPENDIX C *(page 2 of 2)*

| Attitudes | Totally Agree | Agree Very Much | Agree Slightly | Neutral | Disagree Slightly | Disagree Very Much | Totally Disagree |
|---|---|---|---|---|---|---|---|
| 13. If I am to be a worthwhile person, I must be truly outstanding in at least one major respect. | | | | | | | |
| 14. If you don't have other people to lean on, you are bound to be sad. | | | | | | | |
| 15. It is possible for a person to be scolded and not get upset. | | | | | | | |
| 16. I must be a useful, productive, creative person, or life has no purpose. | | | | | | | |
| 17. I can find happiness without being loved by another person. | | | | | | | |
| 18. A person should do well at everything he undertakes. | | | | | | | |
| 19. If I do not do well all the time, people will not respect me. | | | | | | | |
| 20. I do not need the approval of other people in order to be happy. | | | | | | | |
| 21. If I try hard enough, I should be able to excel at anything I attempt. | | | | | | | |
| 22. People who have good ideas are more worthy than those who do not. | | | | | | | |
| 23. A person doesn't need to be well liked in order to be happy. | | | | | | | |
| 24. Whenever I take a chance or risk, I am only looking for trouble. | | | | | | | |

APPENDIX F

# Survey of Pain Attitudes—Revised (SOPA-R)

Please indicate how much you agree with each of the following statements about your pain problem by using the response key below.

*Response key:*
0 = This is very untrue for me.
1 = This is somewhat untrue for me.
2 = This is neither true nor untrue for me (or it does not apply to me).
3 = This is somewhat true for me.
4 = This is very true for me.

| | | | | | |
|---|---|---|---|---|---|
| 1. The pain I feel is a sign that damage is being done | 0 | 1 | 2 | 3 | 4 |
| 2. I will probably always have to take pain medications | 0 | 1 | 2 | 3 | 4 |
| 3. When I hurt, I want my family to treat me better | 0 | 1 | 2 | 3 | 4 |
| 4. If my pain continues at its present level, I will be unable to work | 0 | 1 | 2 | 3 | 4 |
| 5. The amount of pain I feel is out of my control | 0 | 1 | 2 | 3 | 4 |
| 6. I do not expect a medical cure for my pain | 0 | 1 | 2 | 3 | 4 |
| 7. Pain does not have to mean that my body is being harmed | 0 | 1 | 2 | 3 | 4 |
| 8. I have had the most relief from pain with the use of medications | 0 | 1 | 2 | 3 | 4 |
| 9. Anxiety increases the pain I feel | 0 | 1 | 2 | 3 | 4 |
| 10. There is little that I can do to ease my pain | 0 | 1 | 2 | 3 | 4 |
| 11. When I am hurting, I deserve to be treated with care and concern | 0 | 1 | 2 | 3 | 4 |
| 12. I pay doctors so they will cure me of my pain | 0 | 1 | 2 | 3 | 4 |
| 13. My pain problem does not need to interfere with my activity level | 0 | 1 | 2 | 3 | 4 |
| 14. It is the responsibility of my family to help me when I feel pain | 0 | 1 | 2 | 3 | 4 |
| 15. Stress in my life increases the pain I feel | 0 | 1 | 2 | 3 | 4 |
| 16. Exercise and movement are good for my pain problem | 0 | 1 | 2 | 3 | 4 |
| 17. Medicine is one of the best treatments for chronic pain | 0 | 1 | 2 | 3 | 4 |
| 18. My family needs to learn how to take better care of me when I am in pain | 0 | 1 | 2 | 3 | 4 |
| 19. Depression increases the pain I feel | 0 | 1 | 2 | 3 | 4 |
| 20. If I exercise, I could make my pain problem much worse | 0 | 1 | 2 | 3 | 4 |
| 21. I can control my pain by changing my thoughts | 0 | 1 | 2 | 3 | 4 |
| 22. I need more tender loving care than I am now getting when I am in pain | 0 | 1 | 2 | 3 | 4 |
| 23. I consider myself to be disabled | 0 | 1 | 2 | 3 | 4 |
| 24. I have learned to control my pain | 0 | 1 | 2 | 3 | 4 |
| 25. I trust that doctors can cure my pain | 0 | 1 | 2 | 3 | 4 |

*(continued)*

| | | | | | |
|---|---|---|---|---|---|
| 26. My pain does not stop me from leading a physically active life | 0 | 1 | 2 | 3 | 4 |
| 27. My physical pain will never be cured | 0 | 1 | 2 | 3 | 4 |
| 28. There is a strong connection between my emotions and my pain level | 0 | 1 | 2 | 3 | 4 |
| 29. I am not in control of my pain | 0 | 1 | 2 | 3 | 4 |
| 30. No matter how I feel emotionally, my pain stays the same | 0 | 1 | 2 | 3 | 4 |
| 31. When I find the right doctor, he or she will know how to reduce my pain | 0 | 1 | 2 | 3 | 4 |
| 32. If my doctor prescribed pain medications for me, I would throw them away | 0 | 1 | 2 | 3 | 4 |
| 33. I will never take pain medications again | 0 | 1 | 2 | 3 | 4 |
| 34. Exercise can decrease the amount of pain I experience | 0 | 1 | 2 | 3 | 4 |
| 35. My pain would stop anyone from leading an active life | 0 | 1 | 2 | 3 | 4 |

APPENDIX G

# Pain Catastrophizing Scale (PCS)

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint pain, 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 feelings 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 following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

| 0—not at all | 1—to a slight degree | 2—to a moderate degree | 3—to a great degree | 4—all the time |
|---|---|---|---|---|

*When I'm in pain . . .*

1. ☐ I worry all the time about whether the pain will end.
2. ☐ I feel I can't go on.
3. ☐ It's terrible and I think it's never going to get any better.
4. ☐ It's awful and I feel that it overwhelms me.
5. ☐ I feel I can't stand it any more.
6. ☐ I become afraid that the pain will get worse.
7. ☐ I keep thinking of other painful events.
8. ☐ I anxiously want the pain to go away.
9. ☐ I can't seem to keep it out of my mind.
10. ☐ I keep thinking about how much it hurts.
11. ☐ I keep thinking about how badly I want the pain to stop.
12. ☐ There's nothing I can do to reduce the intensity of the pain.
13. ☐ I wonder whether something serious may happen.

. . . Total