PATIENT WOUND PAIN QUESTIONNAIRE

TO BE COMPLETED BY THE PATIENT

Full name __________________________ Date of birth ________________

SECTION A: BACKGROUND/INCIDENT PAIN

1. Is your wound ever painful? *(Please tick)*
   - At rest
   - On movement
   - At wound dressing changes
   *If pain at wound dressing changes only go to Section B*

2. Where is the pain? *(Please tick)*
   - Does it come directly from the wound?
     *Yes* *
     *No* *
   - Do you feel it in the surrounding area?
     *Yes* *
     *No* *
   *Show on the body map where your pain is located*

3. How would you rate your pain? *(Please circle number on the scale that best indicates your current level of pain)*
   0=no pain and 10=worst possible pain

4. How would you describe the pain?
   *Is the pain aching or throbbing, or sharp, dull (like toothache), burning or tingling?*

5. What makes the pain worse?
   - Touch/pressure
   - Movement (ie coughing)
   - Changing positions
   - Dressing changes
   - Night-time
   - Other
   *Give details*

6. What reduces/helps the pain?
   - Pain-relieving medicine
   - Bathing
   - Putting your legs up
   - Other
   *Give details*
SECTION B: PAIN AT WOUND DRESSING CHANGES

7. Do you ever experience pain when your dressing is changed? (Please tick)
   Yes [ ] No [ ]

8. Where is the pain? (Please tick)
   Does it come directly from the wound? Yes [ ] No [ ]
   Do you feel it in the surrounding area? Yes [ ] No [ ]

9. How would you rate your pain before, during and after your wound dressing change? (Please circle a number on each scale that best indicates your current level of pain)
   0=no pain and 10=worst possible pain
   
   Before:
   0  |  1  |  2  |  3  |  4  |  5  |  6  |  7  |  8  |  9  |  10

   During:
   0  |  1  |  2  |  3  |  4  |  5  |  6  |  7  |  8  |  9  |  10

   After:
   0  |  1  |  2  |  3  |  4  |  5  |  6  |  7  |  8  |  9  |  10

10. How long did it take for the pain to go away after the wound dressing was changed?

11. What makes the pain worse? (Please tick)
   Removing dressing [ ] Applying dressing [ ] Dressing type [ ]
   Cleansing [ ] Touch [ ] Other [ ]
   Give details:

12. What reduces/helps the pain? (Please tick)
   Removing dressing myself [ ] Time-outs or brief rests [ ] Dressing type [ ]
   Warm cleansing solutions [ ] Pain-relieving medicines [ ] Other [ ]
   Give details:

Signature of patient
Signature of practitioner:
Date: