NHS
Clifton Court Medical Practice

my Live Well with pain
www.my.livewellwithpain.co.uk

Live Well with Pain **Health Check**

Exploring how pain affects your health and life

Please help us understand about your health and the main obstacles to improving your quality of life and self managing with confidence.

There are **four steps** to completing this Health Check. Please complete all four steps – tick or circle all the answers that apply to you.

STEP 1 How do you feel?

For each statement please circle which is closest to how you have been feeling over the past two weeks

	all of the time	most of the time	more than half the time	less than half the time	some of the time	at no time
I have felt cheerful and in good spirits	**5**	**4**	**3**	**2**	**1**	**0**
I have felt calm and relaxed	**5**	**4**	**3**	**2**	**1**	**0**
I have felt active and vigorous	**5**	**4**	**3**	**2**	**1**	**0**
I woke up feeling fresh and rested	**5**	**4**	**3**	**2**	**1**	**0**
My daily life has been filled with things that interest me	**5**	**4**	**3**	**2**	**1**	**0**

STEP 2 Tell us a bit about your pain

Your current level of pain

Circle one of the numbers on the scale to rate your pain level at present.

0 = 'No pain' 10 = 'Worst/extreme pain'

0	1	2	3	4	5	6	7	8	9	10

Your pain over the last seven days

Circle the number on the scale to rate **how distressing** the pain was on average over the last seven days.

0 = 'No distress' 10 = 'Extremely distressing'

0	1	2	3	4	5	6	7	8	9	10

Managing your pain

Please rate **how confident you are** that you can do the following things at present, despite the pain. Circle one of the numbers on each of the scales.

0 = 'Not at all confident' 6 = 'Completely confident'

"I can live a normal lifestyle, despite the pain"

0	1	2	3	4	5	6

"I can do some form of work, despite the pain"

0	1	2	3	4	5	6

(*work* includes housework, paid and unpaid work)

Now turn over for STEPS 3 and 4

STEP 3 Do you have any problems or difficulties with:

1	Walking or moving about, lack of fitness and stamina	☐
2	Balance or recurrent falls	☐
3	Side effects or problems with current pain medication e.g. tablets etc.	☐
4	Pain relief	☐
5	Understanding why persistent pain occurs	☐
6	An unhelpful pattern of activity of doing too much, getting more pain, then doing too little	☐
7	Eating the right sort of foods, weight changes	☐
8	Disturbed sleep, tiredness or lack of energy	☐
9	Managing mood changes of depression, anger, anxiety or worry	☐
10	Relationship difficulties: with partner, family etc, or sex life concerns	☐
11	Remaining in work or returning to work and/or training	☐
12	Financial or money difficulties	☐
13	Other difficulties (for example, concerns about housing, leisure or social events, drinking, gambling or drug use). Please describe here:	

STEP 4 If you ticked more than three boxes above, please circle **the three most important ones** to change.

Have you completed all four steps?
Please have the completed form with you at your **pain management and medicines review**.
We will look at it together to help explore your concerns, issues and problems linked to your pain. Thank you for helping us understand how your pain is affecting your health and life.

Your name Your date of birth

Date filled in