



# Division of Pain Medicine

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## CHILD PACKET

*For Children ages 8 and above*

Patient ID

Connecticut  
Children's #:

Name:

Child Name: \_\_\_\_\_

This packet contains the following forms for the child/patient to complete:

- ☐ *Adolescent Pediatric Pain Tool (APPT) drawing*
- ☐ *Pain Numeric Rating Scale*
- ☐ *Pain Burden Interview*
- ☐ *'What can you do' form (FDI)*
- ☐ *'When I am in pain' form (PCS-C)*



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## ADOLESCENT PEDIATRIC PAIN TOOL (APPT)

Connecticut  
Children's #:

Patient ID

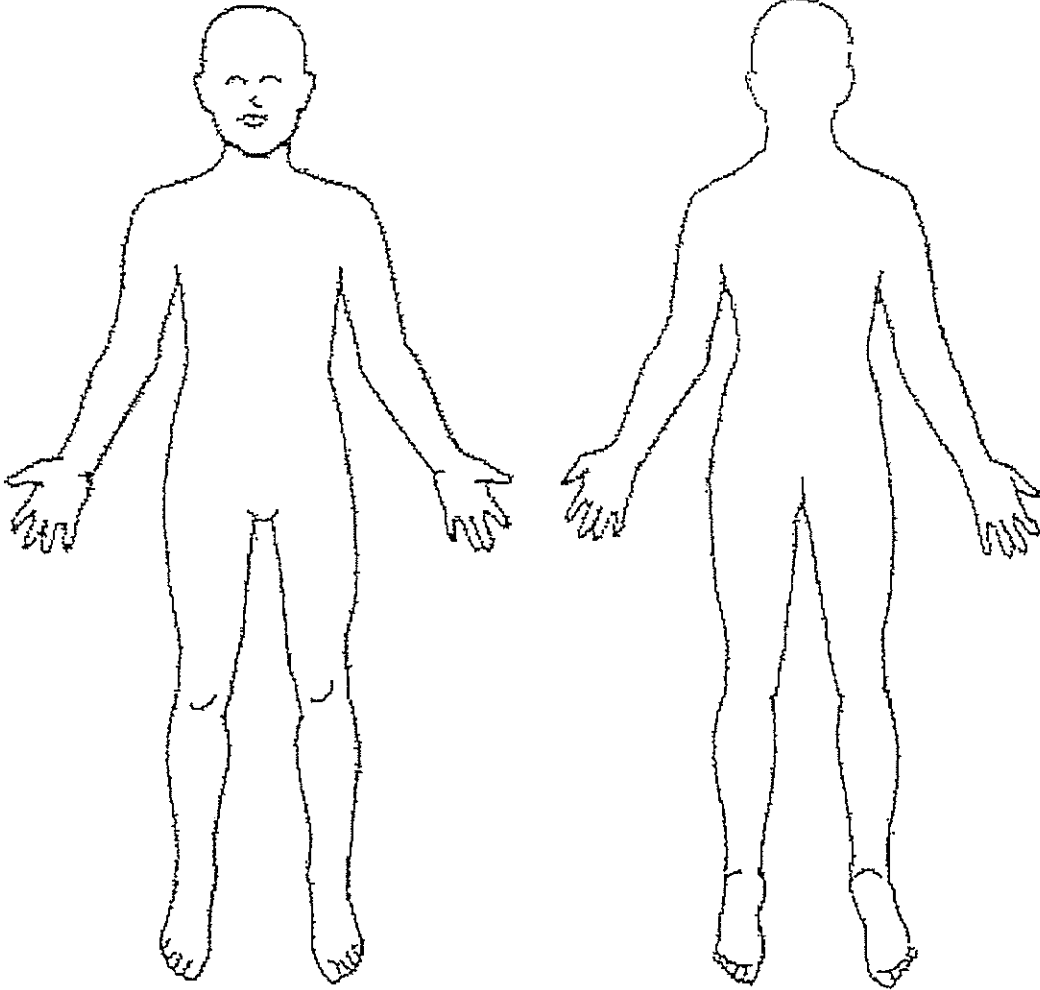
Name:

Patient Name \_\_\_\_\_ Parent (or Guardian) Name \_\_\_\_\_

Date Completed \_\_\_\_\_

### INSTRUCTIONS:

1. Color in the areas on these drawings to show where you have pain. Make the marks as big or small as the place where the pain is.





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## PAIN NUMERIC RATING SCALE

Patient ID
Connecticut Children's #:
Name:

Patient Name \_\_\_\_\_ Parent (or Guardian) Name \_\_\_\_\_

Date Completed \_\_\_\_\_

Please answer the following questions using a scale of 0 to 10.

A score of "0" would be no pain at all and a score of "10" would be the strongest or the worst pain imaginable.

1. How would you rate your **CURRENT** pain?

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										THE STRONGEST OR WORST PAIN YOU CAN IMAGINE

2. How would you rate your **USUAL** level of pain during the last week?

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										THE STRONGEST OR WORST PAIN YOU CAN IMAGINE

3. How would you rate your **LOWEST** level of pain during the last week?

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										THE STRONGEST OR WORST PAIN YOU CAN IMAGINE

4. How would you rate your **WORST** level of pain during the last week?

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										THE STRONGEST OR WORST PAIN YOU CAN IMAGINE



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## PAIN BURDEN INTERVIEW - CHILD REPORT

Connecticut  
Children's #:

Patient ID

Name:

Patient Name \_\_\_\_\_ Parent (or Guardian) Name \_\_\_\_\_

Date Completed \_\_\_\_\_

Think about your pain. In the last month:

1. How many days have you had any pain? ..... ☐ None ☐ A Few ☐ Some ☐ Many ☐ Every
2. How many nights have you slept poorly  
(trouble falling asleep, waking up during sleep) because of pain? ..... ☐ None ☐ A Few ☐ Some ☐ Many ☐ Every
3. How many days have you had trouble taking care of yourself  
(dressing, going to the bathroom, showering) because of pain? ..... ☐ None ☐ A Few ☐ Some ☐ Many ☐ Every
4. How many days have you missed school/work because of pain? ..... ☐ None ☐ A Few ☐ Some ☐ Many ☐ Every
5. How many days have you left school/work early because of pain? ..... ☐ None ☐ A Few ☐ Some ☐ Many ☐ Every
6. How many days have you been unable to do things you enjoy  
because of pain? ..... ☐ None ☐ A Few ☐ Some ☐ Many ☐ Every
7. How many days have you felt sad, mad, or upset because of pain? ..... ☐ None ☐ A Few ☐ Some ☐ Many ☐ Every

0 = None 1 = A Few 2 = Some 3 = Many 4 = Every Total: \_\_\_\_\_



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## WHAT YOU CAN DO (FDI - PATIENT)

Connecticut  
Children's #:

Patient ID

Name:

Patient Name \_\_\_\_\_ Parent (or Guardian) Name \_\_\_\_\_

Date of visit \_\_\_\_\_

When people are sick or having pain it is sometimes difficult for them to do their regular activities. In the last few days, have you had any physical trouble or difficulty doing these activities?

1. Walking to the bathroom? ..... ☐ No Trouble ☐ A Little Trouble ☐ Some Trouble ☐ A Lot of Trouble ☐ Impossible

2. Walking up stairs ..... ☐ No Trouble ☐ A Little Trouble ☐ Some Trouble ☐ A Lot of Trouble ☐ Impossible

3. Doing something with a friend ..... ☐ No Trouble ☐ A Little Trouble ☐ Some Trouble ☐ A Lot of Trouble ☐ Impossible  
(For example, playing a game)

4. Doing chores at home ..... ☐ No Trouble ☐ A Little Trouble ☐ Some Trouble ☐ A Lot of Trouble ☐ Impossible

5. Eating regular meals ..... ☐ No Trouble ☐ A Little Trouble ☐ Some Trouble ☐ A Lot of Trouble ☐ Impossible

6. Being up all day without a nap or rest ..... ☐ No Trouble ☐ A Little Trouble ☐ Some Trouble ☐ A Lot of Trouble ☐ Impossible

7. Riding the school bus or traveling in the car ..... ☐ No Trouble ☐ A Little Trouble ☐ Some Trouble ☐ A Lot of Trouble ☐ Impossible

REMEMBER, YOU ARE BEING ASKED ABOUT DIFFICULTY DUE TO PHYSICAL HEALTH.

8. Being at school all day ..... ☐ No Trouble ☐ A Little Trouble ☐ Some Trouble ☐ A Lot of Trouble ☐ Impossible

9. Doing the activities in gym class ..... ☐ No Trouble ☐ A Little Trouble ☐ Some Trouble ☐ A Lot of Trouble ☐ Impossible  
(or playing sports)

10. Reading or doing homework ..... ☐ No Trouble ☐ A Little Trouble ☐ Some Trouble ☐ A Lot of Trouble ☐ Impossible

11. Watching TV ..... ☐ No Trouble ☐ A Little Trouble ☐ Some Trouble ☐ A Lot of Trouble ☐ Impossible

12. Walking the length of a football field ..... ☐ No Trouble ☐ A Little Trouble ☐ Some Trouble ☐ A Lot of Trouble ☐ Impossible

13. Running the length of a football field ..... ☐ No Trouble ☐ A Little Trouble ☐ Some Trouble ☐ A Lot of Trouble ☐ Impossible

14. Going shopping ..... ☐ No Trouble ☐ A Little Trouble ☐ Some Trouble ☐ A Lot of Trouble ☐ Impossible

15. Getting to sleep at night and ..... ☐ No Trouble ☐ A Little Trouble ☐ Some Trouble ☐ A Lot of Trouble ☐ Impossible  
staying asleep

0 = No Trouble 1 = A Little Trouble 2 = Some Trouble 3 = A Lot of Trouble 4 = Impossible

FDI Total: \_\_\_\_\_



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## WHEN I AM IN PAIN PCS-C

Connecticut  
Children's #:

Patient ID

Name:

Patient Name: \_\_\_\_\_ Parent (or Guardian) Name: \_\_\_\_\_

Date of visit: \_\_\_\_\_ Patient Age: \_\_\_\_\_ Patient Gender: ☐ Male ☐ Female

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint 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 your child is in pain. Below are 13 sentences of different thoughts and feelings. Using the following scale, please indicate the degree to which you have these thoughts and feelings when your child is in pain.

	Not at all	Mildly	Moderately	Severely	Extremely
1. When I am in pain, I worry all the time about whether the pain will end	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2. When I am in pain, I feel I can't go on like this much longer	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
3. When I am in pain, it's terrible and I think it's never going to get better	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4. When I am in pain, it's awful and I feel it overwhelms me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5. When I am in pain, I can't stand it anymore	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6. When I am in pain, I become afraid that the pain will get worse	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7. When I am in pain, I keep thinking of other painful events	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
8. When I am in pain, I want the pain to go away	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
9. When I am in pain, I can't keep it out of my mind	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
10. When I am in pain, I keep thinking about how much it hurts	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
11. When I am in pain, I keep thinking about how much I want the pain to stop	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
12. When I am in pain, there is nothing I can do to stop the pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
13. When I am in pain, I wonder whether something serious may happen	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
0 = Not at all    1 = Mildly    2 = Moderately    3 = Severely    4 = Extremely					PCS Total: _____