

Please take your time to complete this client questionnaire as fully as possible.

The answers you provide will be reviewed by the medical expert writing your report and incorporated into his medicolegal report.

Your contribution is very important and will help explain to the court in your own words the impact your pain has on your life and on those around you.

**You can complete this questionnaire by the following methods:**

* Complete the digital word version, emailed to you with your appointment confirmation letter, and email it back.
* Download the simple word version from our website, print it off, complete it by hand, scan it and email it back.
* Download the simple word version from our website, print it, complete it by hand, keep a copy of it and post the original back making sure that you use the correct postage. Return to Medicolegal Partners, 55 Trent Way, Worcester Park, Surrey KT4 8TW.

**This questionnaire can be found by the following methods:**

* Attached to the email sent to you with your appointment confirmation letter.
* At our website, [www.medicolegal-partners.com](http://www.medicolegal-partners.com), where you can download a word version of it.
* You can also telephone our office on 0207 118 0650 if you prefer a hard copy to be posted to you.

**TO BE COMPLETED AND RETURNED BY 48 HOURS PRIOR TO YOUR MEDICAL CONSULTATION OR YOUR EXAMINATION MAY BE CANCELLED AND A CHARGE INCURRED.**

*All information given remains confidential and is held securely by Medicolegal Partners Limited in accordance with the General Data Protection Regulation 2018. The information helps to simplify and speed up the medicolegal report writing process and is in no way a substitute for a full consultation and examination. The outcome will be based on the information you have provided. Medicolegal Partners Limited accepts no responsibility for advice/information given relating to any incomplete, inaccurate or incorrect information you have provided.*

# Personal Details:

|  |  |
| --- | --- |
| 1. **Name (including title) and Address:** | |
|  | |
|  | |
|  | |
|  | |
| 1. **Daytime Telephone Numbers:** | |
|  | |
|  | |
| 1. **Email Address:** | |
|  | |
| 1. **Date of Birth** | 1. **Date of Accident/Procedure:** |
| |  | | --- | |  | |  |

# Describe Your Pain:

The following sections are designed to give a clear description of each individual area of pain you are experiencing. Pain is usually focused in one specific area but it may radiate out to adjoining areas. For example, the source of pain could be the left

Each page is dedicated to one specific area of pain along with the areas of the

body that specific pain radiates to. For example:

**1.***Mr Smith has pain in his upper left arm with radiates down to the elbow and up to the neck.*

**This arm, elbow and neck pain can all be recorded on the first page.**

**2**. *Mr Smith also has pain in his knee which radiates down to his lower left and ankle.*

**He can record the pain in his knee, lower leg and ankle on the second page.**

**3.** If you have pain in multiple areas, complete as many pages as necessary to provide a complete picture of all of the pain you experience and how it affects you.

There is a diagram for you to annotate to show your pain. The expert doctor will give you a hard copy of this at your examination so that you can complete this by hand. However, if you want to complete it digitally, click on “insert” at the top of the page (3rd tab from the left) and select the “shapes” drop down menu. Choose the shape you would like to use then click on an area in the diagram. The shape will appear and can be moved and resized as you require.

First Area of Pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Subjective description of your pain – *How does your pain feel in this area?*** | | | |
| Character of Pain | Pain Frequency | Aggravating Factors\* | Relieving Factors\* |
| *My pain feels like…* | *How often do you experience your pain?* | *It is aggravated by…* | *It is relieved by…* |
|  |  |  |
|  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Please make no more than 6 suggestions |  |  |  |
|  |  |
| 1. **Other pain issues** | | | |
| If your pain radiates from this area, where does it radiate to? | Does the pain in this area cause any physical issues? | Does the pain in this area cause psychological issues?\* | Does the pain in this area cause any social issues? |
| *It radiates to...* | *My pain causes….* | *My pain causes….* | *It causes….* |
|  |  |  |  |
|  |  |  |
| 1. **Chronology of your pain – *how severe was your pain in this area during the following timeframes (give a score out of ten)?*** | | | |
| When did your pain in this area begin? | At the time of the index event, how severe was this pain? | One month after the index event, how severe was your pain in this area? | How severe is your pain in this area currently? |
|  | /10 | /10 | /10 |

*Please use the space below for additional information about this area of pain.*

Second Area of Pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Subjective description of your pain – *How does your pain feel in this area?*** | | | |
| Character of Pain | Pain Frequency | Aggravating Factors\* | Relieving Factors\* |
| *My pain feels like…* | *How often do you experience your pain?* | *It is aggravated by…* | *It is relieved by…* |
|  |  |  |
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|  |  |  |  |
|  |  |  |  |
| Please make no more than 6 suggestions |  |  |  |
|  |  |
| 1. **Other pain issues** | | | |
| If your pain radiates from this area, where does it radiate to? | Does the pain in this area cause any physical issues? | Does the pain in this area cause psychological issues?\* | Does the pain in this area cause any social issues? |
| *It radiates to...* | *My pain causes….* | *My pain causes….* | *It causes….* |
|  |  |  |  |
|  |  |  |
| 1. **Chronology of your pain – *how severe was your pain in this area during the following timeframes (give a score out of ten)?*** | | | |
| When did your pain in this area begin? | At the time of the index event, how severe was this pain? | One month after the index event, how severe was your pain in this area? | How severe is your pain in this area currently? |
|  | /10 | /10 | /10 |

*Please use the space below for additional information about this area of pain.*

Third Area of Pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Subjective description of your pain – *How does your pain feel in this area?*** | | | |
| Character of Pain | Pain Frequency | Aggravating Factors\* | Relieving Factors\* |
| *My pain feels like…* | *How often do you experience your pain?* | *It is aggravated by…* | *It is relieved by…* |
|  |  |  |
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|  |  |  |  |
| Please make no more than 6 suggestions |  |  |  |
|  |  |
| 1. **Other pain issues** | | | |
| If your pain radiates from this area, where does it radiate to? | Does the pain in this area cause any physical issues? | Does the pain in this area cause psychological issues?\* | Does the pain in this area cause any social issues? |
| *It radiates to...* | *My pain causes….* | *My pain causes….* | *It causes….* |
|  |  |  |  |
|  |  |  |
| 1. **Chronology of your pain – *how severe was your pain in this area during the following timeframes (give a score out of ten)?*** | | | |
| When did your pain in this area begin? | At the time of the index event, how severe was this pain? | One month after the index event, how severe was your pain in this area? | How severe is your pain in this area currently? |
|  | /10 | /10 | /10 |

*Please use the space below for additional information about this area of pain.*

Fourth Area of Pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Subjective description of your pain – *How does your pain feel in this area?*** | | | |
| Character of Pain | Pain Frequency | Aggravating Factors\* | Relieving Factors\* |
| *My pain feels like…* | *How often do you experience your pain?* | *It is aggravated by…* | *It is relieved by…* |
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|  |  |  |  |
| Please make no more than 6 suggestions |  |  |  |
|  |  |
| 1. **Other pain issues** | | | |
| If your pain radiates from this area, where does it radiate to? | Does the pain in this area cause any physical issues? | Does the pain in this area cause psychological issues?\* | Does the pain in this area cause any social issues? |
| *It radiates to...* | *My pain causes….* | *My pain causes….* | *It causes….* |
|  |  |  |  |
|  |  |  |
| 1. **Chronology of your pain – *how severe was your pain in this area during the following timeframes (give a score out of ten)?*** | | | |
| When did your pain in this area begin? | At the time of the index event, how severe was this pain? | One month after the index event, how severe was your pain in this area? | How severe is your pain in this area currently? |
|  | /10 | /10 | /10 |

*Please use the space below for additional information about this area of pain.*

**BRIEF PAIN INVENTORY**



|  |  |  |
| --- | --- | --- |
|  | **QUESTION** | **ANSWER** |
| 1 | Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains and toothaches). Have you had pain other than these every-day kinds of pain? | YES  NO |
| 2 | On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most. | SEE FOLLOWING PAGE FOR DIAGRAM |
| 3 | In the **last 24 hours**, rate your pain at its **worst**, between 0 and 10. (*0 - no pain / 10 – pain as bad as you can imagine*) | /10 |
| 4 | In the **last 24 hours**, rate your pain at its **best**, between 0 and 10. (*0 - no pain / 10 – pain as bad as you can imagine*) | /10 |
| 5 | On the **average**, rate your pain between 0 and 10.  (0 = no pain / 10 – pain as bad as you can imagine) | /10 |
| 6 | How much pain do you have **right now**.  (0 = no pain / 10 – pain as bad as you can imagine) | /10 |
| 7 | In the last 24 hours, how much relief have pain treatments or medications provided? Please give a percentage that most shows how much **relief** you have received.  (*0% = no relief / 100% - complete relief*) | *%* |
| 8 | Indicate below the one number that describes how, during the past 24 hours, pain has interfered with your activities:  **(0 = does not interfere / 10 = completely interferes)** |  |
| A | General activity | /10 |
| B | Mood | /10 |
| C | Walking ability | /10 |
| D | Normal work (includes work outside the home and housework) | /10 |
| E | Relations with other people | /10 |
| F | Sleep | /10 |
| G | Enjoyment of life | /10 |

**S-LANSS Pain Score**

***Leeds Assessment of Neuropathic Symptoms and Signs (self-completed):***

*The Leeds Assessment of Neuropathic Symptoms and Signs (LANSS) Pain Scale[[1]](#footnote-1) has seven items consisting of five symptom items (questions 1 to 5 on the following page) and two examination items (questions 6 and 7). Usually, the examination items are done by a doctor but this self-completed S-LANSS pain score allows people to do this themselves. The purpose of these scales is to assess whether the pain that is experienced is predominantly due to nerve damage or not. Both the LANSS and S-LANSS are scored out of 24; a score of 12 or more is strongly suggestive of neuropathic pain. Note, however, that although the S-LANSS is a useful guide to the type of pain, it should only be viewed as an indicator, and not as a diagnosis.*

Using the diagram, mark where your pain is, putting an X at the site of the worst pain. The expert will give you a hard copy of this to complete at your examination, should you find it easier to complete by hand rather than digitally.

![A drawing of a person

Description automatically generated]()

**Below are 7 questions about the pain shown in the diagram above**

Think about how your pain, as you have shown in the diagram, has felt **over the last week**. Check the box next to the descriptions that best match your pain. Only check responses that describe your pain.

|  |  |  |
| --- | --- | --- |
| **1. In the area where you have pain, do you also have 'pins and needles', tingling or prickling sensations?** | | |
| a) NO - I don't get these sensations | (0) | |
| b) YES - I get these sensations often | (5) | |
| **2. Does the painful area change colour (perhaps looks mottled or more red) when the pain is particularly bad?** | | |
| a) NO - The pain does not affect the colour of my skin | (0) | |
| b) YES - I have noticed that the pain does make my skin look different from normal | (5) | |
| **3. Does your pain make the affected skin abnormally sensitive to touch? Getting unpleasant sensations or pain when lightly stroking the skin might describe this.** | | |
| a) NO - The pain does not make my skin in that area abnormally sensitive to touch | (0) | |
| b) YES - My skin in that area is particularly sensitive to touch | (3) | |
| **4. Does your pain come on suddenly and in bursts for no apparent reason when you are completely still? Words like 'electric shocks', jumping and bursting might describe this.** | | |
| a) NO - My pain doesn't really feel like this | (0) | |
| b) YES - I get these sensations often | (2) | |

|  |  |  |
| --- | --- | --- |
| **5. In the area where you have pain, does your skin feel unusually hot like a burning pain?** | | |
| a) NO - I don't have burning pain. | (0) | |
| b) YES - I get burning pain often. | (1) | |

|  |  |  |
| --- | --- | --- |
| **6. Gently rub the painful area with your index finger and then rub a non-painful area (for example, an area of skin further away or on the opposite side from the painful area). How does the painful area feel when you rub it?** | | |
| a) The painful area feels no different from the non-painful area. | (0) | |
| b) I feel discomfort, like pins and needles, tingling or burning in the painful area that is different from the non-painful area. | (5) | |
| **7. Gently press on the painful area with your finger tip then gently press in the same way onto a non-painful area (the same non-painful area that you chose in the last question). How does this feel in the painful area?** | | |
| a) The painful area does not feel different from the non-painful area | (0) | |
| b) I feel numbness or tenderness in the painful area that is different from the non-painful area. | (3) | |

**McGill Questionnaire**

This is a self-reported questionnaire that allows individuals to give their doctor a good description of the quality and intensity of pain that they are experiencing. You are presented with a list of 78 words in 20 sections that are related to pain. Please mark the words that best describe your overall pain (**multiple markings are allowed**).

|  |  |  |  |
| --- | --- | --- | --- |
| **SENSORY** | | | |
| Flickering  Quivering  Pulsing  Throbbing  Beating  Pounding | Pinching  Pressing  Gnawing  Cramping  Crushing | Pricking  Boring  Drilling  Stabbing  Lancinating | Dull  Sore  Hurting  Aching  Heavy |
| Jumping  Flashing  Shooting | Sharp  Cutting  Lacerating | Tugging  Pulling  Wrenching |  |
| Hot  Burning  Scalding  Searing | Tingling  Itchy  Smarting  Stinging | Tender  Taut  Rasping  Splitting |  |
| **AFFECTIVE** | | | |
| Tiring  Exhausting | Sickening  Suffocating | Punishing  Grueling  Cruel  Vicious  Killing |  |
| Wretched  Blinding | Fearful  Frightful  Terrifying |  |
| **EVALUATIVE** | | | |
| Annoying  Troublesome  Miserable  Intense  Unbearable |  |  |  |
| **MISCELLANOUS** | | | |
| Spreading  Radiating  Penetrating  Piercing | Nagging  Nauseating  Agonising  Dreadful  Torturing | Tight  Numb  Drawing  Squeezing  Tearing | Cool  Cold  Freezing |

**Treatments and medication**

So that the doctor can recommend a treatment plan, including physiotherapy-based rehabilitation, analgesic medication and minimally invasive pain management procedures, please tell us what medications you have taken and how effective they have been. Please only edit those medications that you are taking now or have taken for your pain in the past.

1. **Pharmacological treatments:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Percentage Pain Relief** | **Side Effects Experienced\*** | | |
| **Anti-inflammatory gel**  (Non-steroidal anti-inflammatory medication) | *%* |  |  |  |
| **Amitriptyline**  (Anti-neuropathic medication) | *%* |  |  |  |
| **Baclofen**  (Skeletal relaxant) | *%* |  |  |  |
| **Co-codamol**  (Combination of Codeine and Paracetamol) | *%* |  |  |  |
| **Codeine**  (Weak opioid analgesic medication) | *%* |  |  |  |
| **Diazepam**  (Muscle relaxant) | *%* |  |  |  |
| **Diclofenac**  (Non-steroidal anti-inflammatory drug) | *%* |  |  |  |
| **Duloxetine**  (Anti-neuropathic medication) | *%* |  |  |  |
| **Fentanyl**  (Strong opioid analgesic medication) | *%* |  |  |  |
| **Gabapentin**  (Anti-neuropathic medication) | *%* |  |  |  |
| **Ibuprofen**  (Non-steroidal anti-inflammatory drug) | *%* |  |  |  |
| **Morphine**  (Strong opioid analgesic medication) | *%* |  |  |  |
| **MST Continuous**  (Strong opioid analgesic medication) | *%* |  |  |  |
| **Naproxen**  (Non-steroidal anti-inflammatory drug) | *%* |  |  |  |
| **Oramorph**  (Strong opioid analgesic medication) | *%* |  |  |  |
| **Oxycodone**  (Strong opioid analgesic medication) | *%* |  |  |  |
| **Oxycontin**  (Strong opioid analgesic medication) | *%* |  |  |  |
| **Oxynorm (Oxycodone)**  (Strong opioid analgesic medication) | *%* |  |  |  |
| **Paracetamol**  (Non-opioid analgesic medication) | *%* |  |  |  |
| **Pregabalin**  (Anti-neuropathic medication) | *%* |  |  |  |
| **Tapentadol**  (Moderate opioid analgesic medication) | *%* |  |  |  |
| **Tramadol**  (Moderate opioid analgesic medication) | *%* |  |  |  |
| **Versatis**  (Lidocaine 5% topical patch – Local anaesthetic patch) | *%* |  |  |  |
| **Zomorph**  (Strong opioid analgesic medication) | *%* |  |  |  |

*Please use the space below for any further information on the medication you have taken and their effects.*

Click or tap here to enter text.

1. **Physiotherapy-based rehabilitation:**

(e.g. massage, hydrotherapy, home exercise programme, graded desensitisation)

|  |  |  |
| --- | --- | --- |
| **Treatment** | **Date or range of dates undertaken** | **Outcome** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. **Psychological/psychiatric treatments:**

(e.g. CBT, mindfulness, breathing exercises, psychoanalysis, relaxation techniques)

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| --- | --- | --- |
| **Treatment** | **Date or range of dates undertaken** | **Outcome** |
|  |  |  |
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1. **Alternative medicines**:

(e.g. acupuncture, homeopathy, osteopathy, chiropractic treatment, TENS machine)

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| --- | --- | --- |
| **Treatment** | **Date or range of dates undertaken** | **Outcome** |
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1. **Minimally invasive pain management procedures:**

(e.g. facet joint injection, epidural, local nerve block, radiofrequency denervation, trigger point injection, PENS, pulsed radiofrequency)

|  |  |  |
| --- | --- | --- |
| **Treatment** | **Date or range of dates undertaken** | **Outcome** |
|  |  |  |
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1. **Surgical Procedures:**

|  |  |  |
| --- | --- | --- |
| **Procedure** | **Date undertaken** | **Outcome** |
|  |  |  |
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|  |  |  |
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1. **Advanced pain management techniques:**

(e.g. spinal cord stimulation)

|  |  |  |
| --- | --- | --- |
| **Procedure** | **Date undertaken** | **Outcome** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

# Employment and Activities of Daily Living

VERY IMPORTANT PLEASE NOTE: Complete this section in detail as it provides your opportunity to inform the court how the pain you have or had impacts on your life in your own words. This section is not designed for you to give a medical history, but to help the court understand if and how your life has changed as a result of the accident/incident/procedure and the pain you are now suffering or have suffered. PLEASE COMPLETE EVERY QUESTION.

# 

# Employment:

|  |
| --- |
| **1. Were you employed prior to the index accident/procedure?** |
| YES  NO |
| If yes, in what job role and for how many hours per week? |
|  |
| **2. Were you employed at the time if the index accident/procedure?** |
| YES  NO |
| If yes, in what job role and for how many hours per week? |
|  |
| **3. Are you currently employed?** |
| YES  NO |
| If yes, in what job role and for how many hours per week? |
|  |
| **4. Have you had any time off since the index accident/procedure?** |
| YES  NO |
| If yes, specify the periods of time off work. |
|  |
| **5. Have you adjusted your working practices since the index accident/procedure?** |
| YES  NO |
| If yes, in what way (eg reduction in working hourse, sedentary or light duties only, no lifting, no shift work etc)? |
|  |
| **6. Do you believe that your career has been affected by the index accident/procedure?** |
| YES  NO |
| If yes, in what way? |
|  |
| **7. Have you experienced any financial impact due to the index accident/procedure?** |
| YES  NO |
| If yes, in what way? |
|  |

# Home Life:

Please use this section to describe changes to your home life **SINCE** the index accident/procedure.

|  |
| --- |
| **8. Describe how your ability to undertake domestic tasks and household chores (eg cleaning, laundry, cooking, grocery shopping and vacuuming) has been affected.** |
|  |
| **9. Describe how your ability to undertake personal care and dressing has been affected.** |
|  |
| **10. Describe how your ability to undertake gardening activities has been affected.** |
|  |
| **11. Describe how your ability to undertake DIY has been affected.** |
|  |
| **12. Have you needed additional support at home since the accident/procedure?** |
| YES  NO |
| If yes, in what way? |
|  |
| **13. Have you had to modify your home?** |
| YES  NO |
| If yes, in what way? |
|  |
| **14. Have your hobbies and interests changed?** |
| YES  NO |
| If yes, in what way? |
|  |

**Relationships:**

Please use this section to describe changes to your relationships **SINCE** the index accident/procedure.

|  |
| --- |
| **15. Were your married or in a relationship at the time of the index accident/procedure?** |
| YES  NO |
| If yes, what was the nature of your relationship (eg married, partner) and were your living together or apart? |
|  |
| **16. Has your relationship status changed since the accident/procedure?** |
| YES  NO |
| If yes, in what way? |
|  |
| **17. Has your ability to engage in sexual activity changed?** |
| YES  NO |
| If yes, in what way? |
|  |
| **18. Has your relationship with family members changed?** |
| YES  NO |
| If yes, in what way? |
|  |
| **19. Have your relationships with friends changed?** |
| YES  NO |
| If yes, in what way? |
|  |
| **20. Have there been any changes to your social life?** |
| YES  NO |
| If yes, in what way? |
|  |

1. Source: Bennett, M et al The Journal of Pain, Vol 6, No 3 March, 2005 pp 149-158 The S-LANNS Score for Identifying Pain of Predominantly Neuropathic Origin: Validation for Use in Clinical and Postal Research The Journal 3. [↑](#footnote-ref-1)