HAD Scale

Name Date

read each item and place a firm tick in the box oppostie the reply that comes closest to **how you have been feeling in the past week**

Don't take too long over your replies; your immediate reaction to each item will probably be more accurate than a long thoughout response.

Tick only one box in each section

I feel tense or "wound up"	A
Most of the time.....	3
A lot of the time.....	2
Time to time, Occasionally.....	1
Not at all.....	0

I still enjoy the things I used to enjoy	D
Definitely as much.....	0
Not quite so much.....	1
Only a little.....	2
Hardly at all.....	3

I get a sort of frightened feeling as if something awful is about to happen:	A
Very definitely and quite badly...	3
Yes, but not too badly.....	2
A little, but not too badly.....	1
Not at all.....	0

I can laugh and see the funny side of things:	D
As much as I always could.....	0
Not quite so much now.....	1
Definitely not so much now.....	2
Not at all.....	3

Worrying thoughts go through my mind	A
A great deal of the time.....	3
A lot of the time.....	2
From time to time but not too often	1
Only Occasionally.....	0

I feel cheerful	D
Not at all.....	3
Not often.....	2
sometimes.....	1
Most of the time.....	0

I can sit at ease and feel relaxed	A
Definitely.....	0
Usually.....	1
Not often.....	2
Not at all.....	3

I feel as if I am slowed down:	D
Nearly all the time.....	3
Very Often.....	2
Sometime.....	1
Not at all.....	0

I get a sort of frightened feeling like "butterflies" in the stomach:	A
Not at all.....	0
Occasionally.....	1
Quite often.....	2
Very often.....	3

I have lost interest in my appearance	D
Definitely.....	3
I don't take so much care as I should	2
I may not take quite so much care.....	1
I take just as much care as ever.....	0

I fell restless as if I have to be on the move	A
Very much indeed.....	3
Quite often.....	2
Not very much.....	1
Not at all.....	0

I look forward with enjoyment to things:	D
As much as I ever did.....	0
Rather less than I used to.....	1
Definitely less than I used to....	2
Hardly at all.....	3

I get sudden feelings of panic	A
Very often indeed.....	3
Quite often.....	2
Not very often.....	1
Not at all.....	0

I can enjoy a good book or radio or TV programme	D
Often.....	0
Sometimes.....	1
Not often.....	2
Very Seldom.....	3

Name Date **NEW PATIENT**

BRIEF PAIN INVENTORY

Please circle your response or ask for help if you are having problems.

1 Please rate your pain by circling the one number that best describes your pain at its WORST in the past week

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — PAIN AS BAD AS YOU CAN IMAGINE

2 Please rate your pain by circling the one number that best describes your pain at its LEAST in the past week.

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — PAIN AS BAD AS YOU CAN IMAGINE

3 Please rate your pain by circling the one number that best describes your pain on the AVERAGE

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — PAIN AS BAD AS YOU CAN IMAGINE

4 Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — PAIN AS BAD AS YOU CAN IMAGINE

5 Circle the one number that describes how during the past week, PAIN HAS INTERFERED with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

B. Mood

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

D. Normal work (includes work both outside the home and housework

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

E. Relationships with other people

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

F. Sleep

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE — COMPLETELY INTERFERES

Name Date **FOLLOW UP**

BRIEF PAIN INVENTORY

Please circle your response or ask for help if you are having problems.

1 How much RELIEF have pain treatments or medications FROM THIS CLINIC provided? Please circle the one percentage that shows how much.

100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%

COMPLETE RELIEF NO RELIEF

2 Please rate your pain by circling the one number that best describes your pain at its WORST in the past week

0 1 2 3 4 5 6 7 8 9 10

NO PAIN PAIN AS BAD AS YOU CAN IMAGINE

3 Please rate your pain by circling the one number that best describes your pain at its LEAST in the past week.

0 1 2 3 4 5 6 7 8 9 10

NO PAIN PAIN AS BAD AS YOU CAN IMAGINE

4 Please rate your pain by circling the one number that best describes your pain on the AVERAGE

0 1 2 3 4 5 6 7 8 9 10

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DOES NOT INTERFERE COMPLETELY INTERFERES

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10

DOES NOT INTERFERE COMPLETELY INTERFERES

D. Normal work (includes work both outside the home and housework

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DOES NOT INTERFERE COMPLETELY INTERFERES

E. Relationships with other people

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DOES NOT INTERFERE COMPLETELY INTERFERES