

WINCHESTER NEUROLOGICAL CONSULTANTS, INC.
Translational Analgesic Score

Name: _____ **Chart #** _____ **Date:** _____

For each of the following questions, respond by comparing your current state over the past month to your baseline status before you started our current regimen by circling a number from 0 to 10, with 0 being no improvement and 10 being maximal improvement.

1. Over the past month, my pain treatment has improved my ability to do usual daily activities – including housework, work, school, and/or social activities.
0 1 2 3 4 5 6 7 8 9 10
2. Over the past month, my pain treatment has improved my ability to concentrate on work or daily activities.
0 1 2 3 4 5 6 7 8 9 10
3. Over the past month, my pain treatment has improved the degree to which I feel too tired to do work (feeling that I could not get going and everything I did was an effort) or too tired to perform daily activities and/or socialize because of my pain.
0 1 2 3 4 5 6 7 8 9 10
4. Over the past month, my pain treatment has improved the degree to which I feel distress, restless, agitated, or could go and lie down and/or be alone because of my pain.
0 1 2 3 4 5 6 7 8 9 10
5. Over the past month, my pain treatment has improved my mood or feelings of being depressed, frustrated, anxious, irritable, tense, hopeless, annoyed, or just plain fed up because of my pain.
0 1 2 3 4 5 6 7 8 9 10
6. Over the past month, my pain treatment has improved my ability to sleep.
0 1 2 3 4 5 6 7 8 9 10
7. Over the past month, my pain treatment has improved my ability to walk, sit, and/or stand for long periods.
0 1 2 3 4 5 6 7 8 9 10
8. Over the past month, my pain treatment has improved my ability to up stairs and/or move or lift objects.
0 1 2 3 4 5 6 7 8 9 10
9. Over the past month, my pain treatment has improved the extent to which my pain interferes with optimal interpersonal relationships and/or intimacy.
0 1 2 3 4 5 6 7 8 9 10
10. Over the past month, to which degree have you, your significant other, your family, your coworkers, and/or your friends noticed any improvements in socializing, recreational activities, physical functioning, concentration, mood, interpersonal relationships, activities of daily living, and/or overall quality of life?
0 1 2 3 4 5 6 7 8 9 10

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Numerical Opioid Side Effect Assessment

Name: _____ Chart # _____ Date: _____

	Not Present					As Bad As You Can Imagine					
	0	1	2	3	4	5	6	7	8	9	10
Nausea, vomiting, and/or Lack of appetite.	0	1	2	3	4	5	6	7	8	9	10
Fatigue, sleepiness, trouble concentrating, hallucinations, and/or drowsiness/somnolence	0	1	2	3	4	5	6	7	8	9	10
Constipation	0	1	2	3	4	5	6	7	8	9	10
Itching	0	1	2	3	4	5	6	7	8	9	10
Decreased sexual desire/function, and/or diminished libido	0	1	2	3	4	5	6	7	8	9	10
Dry mouth	0	1	2	3	4	5	6	7	8	9	10
Abdominal pain or discomfort/cramping or bloating	0	1	2	3	4	5	6	7	8	9	10
Sweating	0	1	2	3	4	5	6	7	8	9	10
Headache and/or dizziness	0	1	2	3	4	5	6	7	8	9	10
Urinary retention	0	1	2	3	4	5	6	7	8	9	10