**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Participant ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Think about your current health problem. Read the statements below and place a checkmark in the box to share how often you have these symptoms or feelings.**

|  |  |  |  |
| --- | --- | --- | --- |
| **How often do you experience the following?** | Never | Sometimes | Often |
| Difficulty concentrating |  |  |  |
| Difficulty thinking about anything other than my pain |  |  |  |
| Overwhelmed by my pain or disability |  |  |  |
| Frustrated that I cannot control my pain |  |  |  |
| Loss of energy or motivation to do my usual daily tasks |  |  |  |
| Frustrated that my injury/illness is not fair |  |  |  |
| Frustrated that my case or treatment was not handled correctly |  |  |  |
| No interest in things that I would normally enjoy |  |  |  |
| Feeling angry |  |  |  |
| Feeling that my pain is unbearable |  |  |  |
| Feeling anxious, worrying about my health |  |  |  |
| Feeling like my injured hand/arm is not part of my body |  |  |  |
| Being discriminated against because of who I am (e.g., race, gender, age, appearance, poverty) |  |  |  |
| **How often do you feel the following?** | | | |
| I can do my tasks/roles by doing things in a different way |  |  |  |
| I am satisfied by the things I can do |  |  |  |
| I can cope with my pain and symptoms |  |  |  |
| People understand me |  |  |  |
| I can rely on friends and family to help me |  |  |  |
| I can rely on the health and social system to help me |  |  |  |
| I have enough income and resources to meet my needs |  |  |  |
| My problem is going to improve |  |  |  |
| My future looks good |  |  |  |
|  |  |  |  |
| **If your problem was the result of trauma (an accident, assault, violence, or traumatic event), answer these 2 extra questions. If this does not apply to you, Put an X here \_\_\_\_\_** | | | |
| Flashbacks of the event that feel very real |  |  |  |
| Feeling afraid or anxious when a place or activity reminds me of the event/injury. |  |  |  |

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