**Think about your \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 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  |  |  |  |
| **How often do you feel the following?** |
| That I can adapt to do important things, in a different way  |  |  |  |
| That I can cope with my pain and symptoms  |  |  |  |
| That I can rely on others to help me |  |  |  |
| That my problem is going to improve |  |  |  |
| **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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