Preamble/Introduction
We are currently conducting a survey of the care for chronic pain provided in *insert the name of your community(s).* We want to know about your experience of receiving care for chronic pain in *insert name of community(s).* From this information, we will work with our community of patients and health care providers to determine ways in which we can enhance the care of patients with chronic pain.

Online version of this survey can be accessed at: *Optional – provide an online link to the survey*

Optional for Divisions: After you have completed the survey, please enter to win a (Divisions determine number and type of gift). Incentives are encouraged.

How do we protect your information?
We are asking for your consent to participate in this survey. Your participation will provide us with valuable information that will be used to improve the primary health care system in our community. Your responses are totally anonymous – you won't be identified in any way.

It is important that you know that:

- **Participating in the survey is not necessary for you to receive health services**.
- You may withdraw from the survey at any time.

The survey is anonymous, and no one will be able to link your answers back to you.

- We will not record your name.
- Like all other information you share with your care provider, this form will be treated privately.
- We will not match your survey answers to your medical record at this clinic/hospital.
- Results will be grouped and reported in group form only.
- You have the option of not answering any or all questions.
- This will not impact the care you receive here.
- By completing this survey, you are giving us consent to collect demographic information.
- We are collecting identifiable information in accordance with section 26(e) of the Freedom of Information and Protection of Privacy Act.

If you have any questions, concerns or comments about this survey, please contact [insert local division information here].

Patient Survey: Chronic Pain

EXPERIENCE & SATISFACTION

1. **Overall, how satisfied are you with the health care you receive *for your chronic pain*?**
   - ○ Very satisfied ○ Satisfied ○ Acceptable ○ Dissatisfied ○ Very dissatisfied
   - ○ Prefer not to say ○ Doesn't apply to me

2. **Thinking about the care provider who provides most of the health care *for your chronic pain*, how satisfied are you with the care you receive from this care provider?**
   - ○ Very satisfied ○ Satisfied ○ Acceptable ○ Dissatisfied ○ Very dissatisfied
   - ○ Prefer not to say ○ Doesn't apply to me

ACCESS TO CARE

3. **How easy or difficult was it for you to find a care provider *for your chronic pain*?**
   - ○ Very easy ○ Acceptable ○ Easy ○ Difficult ○ Very difficult
   - ○ Prefer not to say

4. **In the last 12 months, did you have difficulty getting the healthcare or advice you needed *for your chronic pain?***
   - ○ Yes, once ○ Yes, several times ○ Yes, often ○ No
   - ○ Prefer not to say

5. **Please select any barriers for you to attend your scheduled appointments? Check all that apply.**
   - ○ Transportation or money for transportation
   - ○ Childcare availability
   - ○ Location of clinic
   - ○ My work/school schedule
   - ○ Time of appointment
   - ○ Mental or physical health
   - ○ Lack of medical coverage/MSP
   - ○ Issues with provider/clinic
   - ○ Service not available in the area
   - ○ A specialist was unavailable
   - ○ Did not know where to go
   - ○ Do not have personal/family physician
   - ○ Waited too long to get an appointment
   - ○ Waited too long in the waiting room
   - ○ Language barriers
   - ○ Other. Please specify: _____
   - ○ No barriers

ACCEPTABILITY

1. **How satisfied were you with how your care provider involved you in decisions about your care *for your chronic pain*?**
   - ○ Very satisfied ○ Satisfied ○ Acceptable ○ Dissatisfied ○ Very dissatisfied
   - ○ Prefer not to say ○ Doesn't apply to me

2. **How comfortable did you feel talking with your care provider *for your chronic pain*?**
   - ○ Very comfortable ○ Comfortable ○ Acceptable ○ Uncomfortable ○ Very uncomfortable
   - ○ Prefer not to say ○ Doesn't apply to me

3. **Did your care provider take *your chronic pain* health concerns seriously?**
   - ○ Always ○ Frequently ○ Half the time ○ Occasionally ○ Never
   - ○ Prefer not to say ○ Doesn't apply to me

4. **Did your care provider treat you with care and respect?**
   - ○ Always ○ Frequently ○ Half the time ○ Occasionally ○ Never
   - ○ Prefer not to say ○ Doesn't apply to me

EFFECTIVENESS OF CARE

1. **In the last 12 months, have you received everything you need to help you manage *your chronic pain*?**
   - ○ Always ○ Frequently ○ Half the time ○ Occasionally ○ Never
   - ○ Prefer not to say ○ Doesn't apply to me

2. **In the last 12 months, have you had enough support to help you manage *your chronic pain*?**
   - ○ Always ○ Frequently ○ Half the time ○ Occasionally ○ Never
   - ○ Prefer not to say ○ Doesn't apply to me

3. **In general, how effective has your care been in relieving *your chronic pain*?**
   - ○ Very successful ○ Moderately successful ○ Slightly successful ○ Neutral ○ Not successful at all
   - ○ Prefer not to say ○ Doesn't apply to me

4. **In your opinion, what is needed to improve care *for chronic pain* in your community?**

INTEGRATION/CONTINUITY: COLLABORATION

1. **Other than your usual care provider, who else do you see to manage *your chronic pain*?**
   - ○ Only my usual doctor
   - ○ Other family doctor or general practitioner
   - ○ Specialist(s), please specify: _____
   - ○ Nurse practitioner
   - ○ Nurse
   - ○ Nutritionist or dietician
   - ○ Physiotherapist or occupational therapist
   - ○ Psychologist or social worker
   - ○ Complementary or alternative person (e.g., acupuncturist, chiropractor, registered massage therapist, etc.)
   - ○ Other, please specify_____

2. **How well did the team of care providers work together to support *your chronic pain* needs?**

ABOUT YOU

1. What is the underlying condition for your chronic pain?

- ○ Fibromyalgia
- ○ Musculoskeletal origin such as osteoarthrosis, arthritis or rheumatism
- ○ Low back pain
- ○ Trauma/injury
- ○ Genetically predisposed hypermobility
- ○ Unknown
- ○ Other. Please specify_____

2.	Month	Year	Doesn't apply to me
Approximately, when did your chronic pain begin?			
Approximately, when did you seek help for your chronic pain?			
Approximately, when did your treatment for your chronic pain start?			
Approximately, when did your treatment for your chronic pain end? _____Still receiving care If your treatment for your treatment ended, what is the reason?			

3. Describing your pain	0= No pain 10= Pain as bad as you can imagine
What number best describes your pain on average in the past week?	
What number best describes how, during the past week, pain has interfered with your enjoyment of life?	
What number best describes how, during the past week, pain has interfered with your general activity?	

4. How much your pain affects your ability to participate in the following activities?

	Same/just as able	Less able	No longer able
Walking			
Lifting			
Exercising			
Doing household chores			
Driving			
Attending social activities			
Working outside the home			
Sleeping			
Maintaining relationships with friends and family			
Maintaining an independent lifestyle			
Having sexual relations			
Other. Please specify:			

5. **How has your pain impacted your health in the following areas?**

	No impact	Small/mild impact	Large/major impact
Mental health			
Alcohol use			
Marijuana use			
Other (illicit) drug use			

6. **Please select the statement below that best describes your chronic pain:**
- ○ Mild chronic pain: low intensity pain, with few functional limitations
- ○ Moderate chronic pain: low to moderate intensity pain, some functional limitations
- ○ Severe complex chronic pain: moderate to high intensity pain, significant functional limitations, potential for multiple complexities and comorbidities

ABOUT YOUR TREATMENT

1. **Approximately, how many times have you visited your family physician for care related to your chronic pain in the past month?** _____

2. **Approximately, how many times have you visited your emergency department for care related to your chronic pain in the past month?** _____

3. **What other health care services have you used for your chronic pain in the past month?**

4. **What type of care do/did you receive for your chronic pain? Check all that apply.**
- ○ Medication
- ○ Traditional medicine (i.e. herbal medicine)
- ○ Acupuncture
- ○ Thermotherapy
- ○ Exercise
- ○ Massage
- ○ Nutritional regime
- ○ Meditation
- ○ Counselling
- ○ Group medical visits
- ○ Education/self- management for your chronic pain
- ○ Pain management support group (community support group, Chronic Pain Anonymous)
- ○ Crisis line
- ○ Other. Please specify_____

a. **If you answered yes to receiving medication for your chronic pain, what medications do you currently use:**
- ○ NSAIDs (i.e. Ibuprofen, Aleve, Aspirin)
- ○ narcotic analgesics (i.e. Percocet, oxycodone, oxycontin, Tylenol with codeine, Tylox)
- ○ beta-blockers (i.e. Sectral, Atenolol, Zebeta, Lopressor, Toprol-XL
- ○ cox-2 inhibitors (i.e. Celebrex and Bextra)
- ○ muscle relaxants (i.e. Baclofen, Lorzone, Parafon Forte DSC)
- ○ anti-depressants (i.e. Duloxetine)
- ○ anti-convulsants (i.e. Gabapentin, Clobazam. Frisium. Clonazepam)
- ○ Other. Please specify_____

5. **In general, how successful have these therapies been in relieving your chronic pain?**

	Very successful	Moderately successful	Slightly successful	No impact	Not applicable
Medication					
Traditional medicine (herbal medicine)					
Acupuncture					
Thermotherapy					
Exercise					
Massage					
Nutritional regime					
Meditation					
Counselling					
Group medical visit					
Education/self- management for your chronic pain					
Pain management group (community support group, Chronic Pain Anonymous					
Crisis line					
Other. Please specify:					

DEMOGRAPHICS

1. Gender
   - ○ Male
   - ○ Female
   - ○ X
   - ○ Prefer not to say
2. What year were you born _____ (year)
3. Do you have a family doctor?
   - ○ Yes, I had a family doctor before I developed chronic pain
   - ○ Yes, I have a family doctor since developing chronic pain
   - ○ No
   - ○ Prefer not to say
4. What community do you receive most of your care for *your chronic pain:*
   _____
5. What other community(ies) do you receive some of your care *your chronic pain:*
   _____
6. Do you live in the same community where you receive your care *your chronic pain*?
   - ○ Yes
   - ○ No
   - ○ Prefer not to say
7. How long did it take to get to your appointments? _____ (minutes)