Occupational Understanding of Challenges– Chronic Pain Questionnaire (OUCH-CPQ)

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This instrument is designed to be used by occupational therapists in the provision of services to individuals who live with chronic pain. The assessment aims to explore the influence of chronic pain on daily activities, occupations, and overall well-being.

Instructions for administration of the OUCH-CPQ:

The assessment can be given to individuals as a questionnaire to complete on their own, or used as a guide for an interview conducted by the occupational therapist. The various sections of the assessment are completed in the order presented, and according to the instructions stated in each area of the instrument. These sections include pain location, pain description, and areas of occupation (self-care, etc.), and goals. The therapist completes the information sheet.

When the assessment is administered as an interview the therapist reads each question to the person and documents his or her response on the spaces provided. The therapist provides clarification when needed, and probes for additional information if answers from the person are incomplete. In the “Sensitive Areas” section, the individual is asked if he or she would like to discuss more sensitive areas of his or her life, such as intimacy, spirituality, and emotional well-being. If the person would like to discuss these areas with the therapist, the interview proceeds accordingly. In the “My Goals” section at the end of the assessment, the person is asked to clarify what he or she would like to accomplish in occupational therapy.
OCCUPATIONAL UNDERSTANDING OF CHALLENGES –
CHRONIC PAIN QUESTIONNAIRE (OUCH-CPQ)

(Pages 1-10 may be completed by therapist interview or patient self-assessment.)

PATIENT’S NAME:

DATE:

PAIN LOCATION

Where is your pain located? Please use the figure below to mark the area(s) of your pain.

Note: If you are completing this assessment on a computer and are unable to mark the figure, please move to the next item and describe the location of your pain in detail.
PAIN DESCRIPTION

Please describe your pain in detail. Be as specific as possible regarding location, intensity, and positions or activities that make it worse or better.
### Chronic Pain Descriptor Scale

<table>
<thead>
<tr>
<th>Which picture below best represents your pain?</th>
<th>Which comment below best describes how pain affects your life?</th>
</tr>
</thead>
<tbody>
<tr>
<td>![Very little or No Pain]</td>
<td>I feel like I could do almost anything.</td>
</tr>
<tr>
<td>![Mild Pain]</td>
<td>The pain is always present, but it doesn’t stop me.</td>
</tr>
<tr>
<td>![Moderate Pain]</td>
<td>I can do almost anything I want to do if I pace myself and take rest breaks.</td>
</tr>
<tr>
<td>![Terrible Pain]</td>
<td>I can do some of the activities I want to do, but sometimes the pain keeps me from enjoying life.</td>
</tr>
<tr>
<td>![Worst Pain Imaginable]</td>
<td>Most of the things I want to do are so difficult, I can’t manage it.</td>
</tr>
<tr>
<td></td>
<td>I can’t do anything.</td>
</tr>
</tbody>
</table>
Describe how your pain is affecting your daily life.

Are there activities that you would like to do but are unable to perform because of the pain?

What would you like your medical team to know about your pain?

What would you like your family to know about your pain?
PLEASE COMPLETE THE FOLLOWING SENTENCES:

On days when my pain is manageable, I like to:

On days when the pain is bad, I usually:

**Self Care**

How does your pain affect your ability to:

- get in and out of bed?

- get in and out of your tub or shower?

- perform your bathing and grooming?

- get dressed and undressed?

Does anyone help you with any of the above? Who?

Does your pain affect your ability to sleep? Describe.
**Mobility**

Do you use a device to help you walk or get around? Examples: walker, cane, wheelchair, scooter, etc.

Does your pain affect your ability to get around in your home? Explain:

Does your pain affect your ability to get around in the community? Explain.
### Household

How does your pain affect your ability to:

- Care for your family or pets?
- Prepare meals?
- Take your medications?
- Use your telephone or computer?
- Clean your home?
- Do laundry?
Maintain the exterior of your home, including yard work like cutting grass or removing snow?

Drive?

Run errands?

Shop for groceries and other items?

Does anyone help you with any of the above? Who?
**Work/Education**

Do you currently work or attend school?

How does your pain affect your ability to perform duties in work and school?

Does anyone help you with any of the above? Who?

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**Leisure**

What do you do for enjoyment in your spare time?

Are there any activities you would like to engage in but your pain limits your ability to do so?

Does anyone help you with any of the above? Who?
**Friends and Family**

Does your pain limit your ability to visit with friends and family? Explain:

Does your pain interfere with your ability to participate in any clubs or organizations?

Does anyone help you with any of the above? Who?

Would you like to receive information about chronic pain support groups in your area?

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**Sensitive Areas**

Chronic pain may affect some sensitive areas which have not yet been mentioned. These may include intimacy, spirituality, and emotional well-being. Would you like to address any of these now or in the future? (circle one) Yes No

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**My Goals**

Is your pain limiting important things in your life?

What would you like to be able to do in the future?

What would you like to work on in occupational therapy?
CHRONIC PAIN QUESTIONNAIRE (OUCH-CPQ)

INFORMATION SHEET

This page is optional and may be completed by the therapist.

Patient’s Name:

Diagnosis:

Date of Birth:

Precautions:

Medications:

Past medical history:

History of present chronic pain condition (date of onset, etc.):

General Observations:

Therapist’s Name:

Today’s Date: