The Occupational Understanding of Challenges Chronic Pain Questionnaire (OUCH-CPQ 3)

Assessment Tool

Copyright 2008. Misericordia University, Dallas, PA.

Revision of:
Occupational Understanding of Challenges – Chronic Pain Questionnaire (OUCH-CPQ)
Copyright 2007. College Misericordia, Dallas, PA.

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 3:

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.

At the end of the assessment, a copy of the goals should be provided to the person.

A chronic pain diary is included with this assessment for the person’s use. The diary can be copied and used to track daily changes in activity level, pain level, self-help techniques used, as well as progress made towards meeting goals. The therapist should explain how to use the diary and encourage use during therapy sessions as well as at home or work.

*Note: This assessment may be reproduced as a two-sided document.*
Ouch-CPQ 3

Occupational Understanding Of Challenges—

Chronic Pain Questionnaire, revised.

(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**

Which color/comment above best describes how pain affects your life?

_____________________________________________________________________________
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?

☐ Yes  ☐ No

If yes, please explain: ____________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

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? _______________________________________________________

Comments: _____________________________________________________________________
______________________________________________________________________________

Does anyone help you with any of the above? Yes No

Who? ___________________________ How often? ________________________________

Does your pain affect your ability to sleep? Yes No ~ If yes, please describe:

______________________________________________________________________________
**Mobility**

Do you use a device to help you walk or get around? (Examples: walker, cane, wheelchair, scooter, etc.)  
☐ Yes  ☐ No

Does your pain affect your ability to get around in your home?  
☐ Yes  ☐ No

Does your pain affect your ability to get around in the community?  
☐ Yes  ☐ No

If yes to any of the above, please explain: ____________________________________________

-----------------------------------------------------------------------------------------------

**Household**

How does your pain affect your ability to:

Care for your family or pets? __________  Prepare meals? ______________________________ 

Take your medications? ___________  Use your telephone? ____________________________ 

Use your computer? _______________  Clean your home? ____________________________

Do laundry? _________________  Drive? ______________________________________ 

Run errands? ___________________  Shop for groceries and other items? __________ 

Maintain the exterior of your home, including yard work like cutting grass or removing snow? _____________________________________________________________________

Comments: __________________________________________________________________________ 

-----------------------------------------------------------------------------------------------

Does anyone help you with any of the above?  
☐ Yes  ☐ No

Who? ___________________________  How often? _______________________________________
**Work/Education**

Do you currently work or attend school? □ Yes □ No

How does your pain affect your ability to perform duties in work and/or school? __________
_____________________________________________________________________________
_____________________________________________________________________________

Does anyone help you with any of the above? □ Yes □ No

Who? __________________________ How often? ________________________________

**Leisure**

What do you do for enjoyment in your spare time? ______________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Does anyone help you with any of the above? □ Yes □ No

Who? __________________________ How often? ________________________________

Are there any activities you would like to engage in but your pain limits your ability to do so?
☐ Yes ☐ No

If yes, please explain: __________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
**Friends, Family, and Community**

Does your pain limit your ability to visit with friends and family?  
☐ Yes  ☐ No

Does your pain interfere with you ability to participate in any clubs or organizations?  
☐ Yes  ☐ No

If yes, please explain:______________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Does anyone help you with any of the above?  ☐ Yes  ☐ No

Who? __________________________ How often? _________________________________

Would you like to receive information about chronic pain support groups in your area?  
☐ Yes  ☐ No

Group: __________________________ Contact person: ____________________________
Address: __________________________ Phone: _________________________________

**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 express concerns in any of these areas now? Any information you share will remain confidential.

☐ Yes  ☐ No
**My Goals**

Successful completion of goals requires a personal investment of time and motivation to restore or maintain function in your daily life. Are you willing to help create and commit to your goals and be an active member of your treatment program?  

[ ] Yes  [ ] No

What makes life most worthwhile?

______________________________________________________________________________

______________________________________________________________________________

What goals might help you achieve a better life?

______________________________________________________________________________

______________________________________________________________________________

Do these goals address certain activities that you can’t currently do?

______________________________________________________________________________

______________________________________________________________________________

What can you do to reach these goals?

______________________________________________________________________________

______________________________________________________________________________

What have you done to reach these goals?

______________________________________________________________________________

______________________________________________________________________________

What are you currently doing to reach these goals?

______________________________________________________________________________

______________________________________________________________________________
What do you need to accomplish these goals?
______________________________________________________________________________
______________________________________________________________________________

How often would you like to participate in activities that you can’t currently do?
______________________________________________________________________________
______________________________________________________________________________

How long does this activity(s) usually take?
______________________________________________________________________________
______________________________________________________________________________

How can your medical team assist you with your goals?
______________________________________________________________________________
______________________________________________________________________________

What would make life less worth living?
______________________________________________________________________________
______________________________________________________________________________
<table>
<thead>
<tr>
<th>Day</th>
<th>Accomplishments:</th>
<th>Obstacles:</th>
<th>Pain level/color:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunday</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monday</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuesday</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wednesday</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thursday</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friday</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saturday</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>