Pain in Dystonia (PIDS) – Assessment Tool

1. SEVERITY
   Which body parts are most affected by pain? How often do you experience pain in each body part?

How often do you experience pain in your **neck and shoulders?** ☐ No pain in this body part ☐ Less than 1 day per week ☐ 2-4 days per week ☐ 5 or more days per week	Please indicate pain at **its worst** in regards to neck and shoulder pain? No Pain ________________ Worst Pain Imaginable Please indicate pain **on average** in regards to neck and shoulder pain? No Pain ________________ Worst Pain Imaginable On the days that you experience pain in your neck and shoulders, how many **hours** do you suffer pain on average? ______
How often do you experience pain or other uncomfortable sensations around your **eyes?** ☐ No pain in this body part ☐ Less than 1 day per week ☐ 2-4 days per week ☐ 5 or more days per week	Please indicate pain at **its worst** in regards to eye pain? No Pain ________________ Worst Pain Imaginable Please indicate pain **on average** in regards to eye pain? No Pain ________________ Worst Pain Imaginable On the days that you experience pain in your eyes, how many **hours** do you suffer pain on average? ______
How often do you experience pain in your **jaw?** ☐ No pain in this body part ☐ Less than 1 day per week ☐ 2-4 days per week ☐ 5 or more days per week	Please indicate pain at **its worst** in regards to jaw pain? No Pain ________________ Worst Pain Imaginable Please indicate pain **on average** in regards to jaw pain? No Pain ________________ Worst Pain Imaginable On the days that you experience pain in your jaw, how many **hours** do you suffer pain on average? ______
How often do you experience pain in your **arms?** ☐ No pain in this body part ☐ Less than 1 day per week ☐ 2-4 days per week ☐ 5 or more days per week	Please indicate pain at **its worst** in regards to arm pain? No Pain ________________ Worst Pain Imaginable Please indicate pain **on average** in regards to arm pain? No Pain ________________ Worst Pain Imaginable On the days that you experience pain in your arms, how many **hours** do you suffer pain on average? ______
How often do you experience pain in your **legs?** ☐ No pain in this body part ☐ Less than 1 day per week ☐ 2-4 days per week ☐ 5 or more days per week	Please indicate pain at **its worst** in regards to leg pain? No Pain ________________ Worst Pain Imaginable Please indicate pain **on average** in regards to leg pain? No Pain ________________ Worst Pain Imaginable On the days that you experience pain in your legs, how many **hours** do you suffer pain on average? ______
How often do you experience pain in your **mid lower back?** ☐ No pain in this body part ☐ Less than 1 day per week ☐ 2-4 days per week ☐ 5 or more days per week	Please indicate pain at **its worst** in regards to mid lower back pain? No Pain ________________ Worst Pain Imaginable Please indicate pain **on average** in regards to mid lower back pain? No Pain ________________ Worst Pain Imaginable On the days that you experience pain in your mid lower back, how many **hours** do you suffer pain on average? ______

2. FUNCTIONAL IMPACT

Pain can impact daily life activities. Please rate the degree that **PAIN** has on the following activities.

	N/A	No interference (0)	Sometimes interferes (1)	Often interferes (2)	Unable to perform this due to pain (3)
Engaging in physical exercise					
Participating in social events and gatherings					
Completing household activities i.e., cooking, leaning.					
Driving					
Getting a good night sleep or rest					
Outdoor leisure activities					
Working					
Personal relationships					

3. EXTERNAL FACTORS

Some external factors can **trigger pain** or make it worse. Using the scale, please indicate the degree to which these factors affect you.

	N/A	No effect (0)	Mild effect (1)	Moderate effect (2)	Severe effect (3)
Heat or cold or both					
Bright lights or changes in lighting					
Exercise					
Manipulation or Massage					
Changes in posture (e.g., standing, sitting or lying down)					
Time of day					
Stress					
Prolonged fixed position					

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Some external factors can provide **relief of pain**. Using the scale, please indicate the degree to which these strategies improve your pain.

	N/A	No relief (0)	Mild relief (1)	Moderate relief (2)	Complete relief (3)
Heat or cold or both					
Physical rest					
Exercise					
Sleep					
Manipulation or Massage					
Stretching					
Relaxation techniques					
Actions/gestures you do to alleviate dystonia *(these are actions used by some patients to alleviate dystonia i.e resting your head on the headrest, touching chin or face, massaging your eyes or other actions)*					
Changes in posture (e.g. standing, sitting or lying down)					
Alcohol					
Self prescribed treatments					