Central Sensitization Inventory: Part A

Please circle the best response to the right of each statement

I feel un-refreshed when I wake up in the morning.	Never	Rarely	Sometimes	Often	Always
My muscles feel stiff and achy.	Never	Rarely	Sometimes	Often	Always
I have anxiety attacks.	Never	Rarely	Sometimes	Often	Always
I grind or clench my teeth.	Never	Rarely	Sometimes	Often	Always
I have problems with diarrhea and/or constipation.	Never	Rarely	Sometimes	Often	Always
I need help in performing my daily activities.	Never	Rarely	Sometimes	Often	Always
I am sensitive to bright lights.	Never	Rarely	Sometimes	Often	Always
I get tired very easily when I am physically active.	Never	Rarely	Sometimes	Often	Always
I feel pain all over my body.	Never	Rarely	Sometimes	Often	Always
I have headaches.	Never	Rarely	Sometimes	Often	Always
I feel discomfort in my bladder and/or burning when I urinate.	Never	Rarely	Sometimes	Often	Always
I do not sleep well.	Never	Rarely	Sometimes	Often	Always
I have difficulty concentrating.	Never	Rarely	Sometimes	Often	Always
I have skin problems such as dryness, itchiness or rashes.	Never	Rarely	Sometimes	Often	Always
Stress makes my physical symptoms get worse.	Never	Rarely	Sometimes	Often	Always
I feel sad or depressed.	Never	Rarely	Sometimes	Often	Always
I have low energy.	Never	Rarely	Sometimes	Often	Always
I have muscle tension in my neck and shoulders.	Never	Rarely	Sometimes	Often	Always
I have pain in my jaw.	Never	Rarely	Sometimes	Often	Always
Certain smells, such as perfumes, make me feel dizzy and nauseated.	Never	Rarely	Sometimes	Often	Always
I have to urinate frequently.	Never	Rarely	Sometimes	Often	Always
My legs feel uncomfortable and restless when I am trying to go to sleep at night.	Never	Rarely	Sometimes	Often	Always
I have difficulty remembering things.	Never	Rarely	Sometimes	Often	Always
I suffered trauma as a child.	Never	Rarely	Sometimes	Often	Always
I have pain in my pelvic area.	Never	Rarely	Sometimes	Often	Always

TOTAL _____

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Central Sensitization Inventory: Part B

Have you been diagnosed by a doctor with any of the following disorders?

Please check the box to the right for each diagnosis and write the year of diagnosis

	No	Yes	Diagnosed
1. Restless leg syndrome			
2. Chronic fatigue syndrome			
3. Fibromyalgia			
4. Temporomandibular joint disorder (TMJ)			
5. Migraine or tension headaches			
6. Irritable bowel syndrome			
7. Multiple chemical sensitivities			
8. Neck injury (including whiplash)			
9. Anxiety or panic attacks			
10. Depression			

DASS Questionnaire

Please read each statement and circle a number, o, 1, 2, or 3, which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

S = _____ A = _____ D = _____

0 = It did not apply to me at all
1 = Applied to me to some degree or some of the time
2 = Applied to me a considerable degree, or a good part of the time
3 = Applied to me very much, or most of the time

I find it hard to wind down……	S	0	1	2	3
I was aware of dryness of my mouth…….	A	0	1	2	3
I could not seem to experience any feeling at all……..	D	0	1	2	3
I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness					
In the absence of physical exertion……	A	0	1	2	3
I found it difficult to work up the initiative to do things……..	D	0	1	2	3
I tended to over-react to situations……..	S	0	1	2	3
I experienced trembling (e.g. hands)……	A	0	1	2	3
I felt that I was using a lot of nervous energy……	S	0	1	2	3
I was worried about situations in which I might panic and make a fool of myself…..	A	0	1	2	3
I felt that I had nothing to look forward to……..	D	0	1	2	3
I found myself getting agitated……..	S	0	1	2	3
I found it difficult to relax……..	S	0	1	2	3
I felt down-hearted and blue……..	D	0	1	2	3
I was intolerant of anything that kept me from getting on with what I was doing….	S	0	1	2	3
I felt I was close to panic……..	A	0	1	2	3
I was unable to become enthusiastic about anything……..	D	0	1	2	3
I felt I was not much of a person……..	D	0	1	2	3
I felt that I was rather touchy……	S	0	1	2	3
I was aware of the action of my heart in the absence of physical exertion (e.g.					
Sense of heart rate increase, heart missing a beat)……	A	0	1	2	3
I felt scared without any good reason……..	A	0	1	2	3
I felt that life was meaningless……..	D	0	1	2	3

PSEQ-2

(Michael. K Nicholas, PhD, Brian E. McGuire, PhD, and Ali Asghari, PhD)

Please rate how **confident** you are that you can do the following things at present, **despite the pain.** To indicate your answer circle one of the numbers on the scale under each item, where 0 = not at all confident and 6 = completely confident.

Remember, this questionnaire is not asking whether or not you have been doing these things, but rather **how confident you are that you can do them at present, despite the pain.**

1.	I can do some form of work, despite the pain ("work" includes housework and paid and unpaid work)	0 Not at all confident	1	2	3	4	5	6 Completely confident
2.	I can live a normal lifestyle, despite the pain	0 Not at all confident	1	2	3	4	5	6 Completely confident

Patient name: _____ DOB: _____ Date: _____

PANAS

(Reference: Watson, D., Clark, L. A., & Tellegan, A. 1988)

This scale consists of a number of words that describe different feelings and emotions. Read each item and then list the number from the scale below next to each word. Indicate to what extent you feel this way right now, that is, at the present moment *OR* indicate the extent you have felt this way over the past week. Please circle if you used this measure for the present moment or over the past week.

1	2	3	4	5
Very slightly or not at all	**A little**	**Moderately**	**Quite a bit**	**Extremely**

1. ____ Interested
2. ____ Distressed
3. ____ Excited
4. ____ Upset
5. ____ Strong
6. ____ Guilty
7. ____ Scared
8. ____ Hostile
9. ____ Enthusiastic
10. ____ Proud
11. ____ Irritable
12. ____ Alert
13. ____ Ashamed
14. ____ Inspired
15. ____ Nervous
16. ____ Determined
17. ____ Attentive
18. ____ Jittery
19. ____ Active
20. ____ Afraid

PCS Questionnaire

(Reference: Quartana et al. 2009)

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are 13 statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you experience pain.
0 = not at all 1 = to a slight degree 2 = to a moderate degree 3 = to a great degree 4 = all the time

When I'm in pain……

(H) _____ I worry all the time about whether the pain will end

(H) _____ I feel I can't go on

(H) _____ It's terrible and I think it's never going to get any better

(H) _____ It's awful and I feel that it overwhelms me

(H) _____ I feel I can't stand it anymore

(M) _____ I become afraid that the pain will get worse

(M) _____ I keep thinking of other painful events

(R) _____ I anxiously want the pain to go away

(R) _____ I can't seem to keep it out of my mind

(R) _____ I keep thinking about how much it hurts

(R) _____ I keep thinking about how badly I want the pain to stop

(H) _____ There's nothing I can do to reduce the intensity of my pain

(M) _____ I wonder whether something serious will happen

TOTAL: _____

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