Appendixes
to *New Possibilities*

Self-Evaluation Forms

The questionnaires in this section correspond with sections of the book as follows:

Appendix A: Parts 1 and 2 (Chapters 1–10)

Appendix B: Part 3 (Chapters 11–16)

Appendix C: Part 4 (Chapters 17–18)

Appendix A

Physical Impact Assessments

The questionnaires in this section correspond with Parts 1 and 2 in the book (Chapters 1–10)

A-1. Physical Impacts Inventory

Read each statement. Check (√) the column that indicates how true you believe that statement to be TODAY. Please address all the items.

My experience today is that ...	0—Not at all	1—Somewhat	2—Moderately	3—A lot	4—Extremely
Sleep Disruption					
I sleep lightly or wake easily in the night					
I cannot fall asleep easily					
I wake many times during the night					
When I wake, I stay awake for long periods without being able to fall back asleep					
I wake up earlier than planned					
I do not feel rested or restored after sleep					
I sleep excessively					
Physical De-activation					
I engage in avoidance behaviors (e.g., thoughts, feelings, behaviors, and experiences; avoiding daily responsibilities; sleeping excessively; using substances)					
I cannot engage in ordinary movement (e.g., walking, sitting up, lifting)					
I cannot complete important tasks (e.g., household, work, recreational, relationship, family)					
I engage in guarding and protecting behaviors (e.g., avoiding certain movements, trying not to bend or kneel, sitting sideways to dress, lifting with only one side)					
I engage in excessive downtime (e.g., sitting, lying down, being inactive)					
I cannot engage in daily routines					
I cannot engage in daily activities					
I cannot complete activities of daily living (e.g., bathing, brushing teeth, dressing)					
I cannot use proper body mechanics					
I use a prosthetic device (e.g., cane, back brace, walker, crutches)					

Physical De-conditioning					
I have a restricted range of motion					
I have medical complications					
I have damage to physical systems (e.g., immune system, breathing, circulation)					
I've gained or lost weight					
My pain tolerance has decreased					
I've lost strength					
I've lost flexibility					
I've lost function (e.g., ability to do or complete physical tasks or be physically independent)					
I've lost physical comfort					
Physical tension in my body has increased					
I have impaired motor control					
I have poor balance					
I have decreased mobility					
I have more medical problems					
I have more complications to existing medical conditions					
I have physical atrophy					
I have little energy					
Cognitive Impact					
I have poor attention					
I have poor concentration					
I have poor short-term memory					
I have poor mental flexibility					
I have poor verbal ability					
I have poor mental processing (speed and response)					
I have difficulty completing tasks					
I have poor motor performance					
I have poor executive function (e.g., ability to use memory, concentration, attention, focus, and problem-solving to monitor, manage, and achieve goals)					
I have poor multitasking ability					
I have poor reaction time					
I have poor decision-making ability					
I have poor long-term memory					

A-2. Post-Injury Physical Experience Inventory

Read each statement. Check (√) the column that indicates how true you believe that statement to be SINCE YOUR INJURY OR ILLNESS. Please address all the items.

Since my injury or illness ...	**0—Not at all**	**1—Somewhat**	**2—Moderately**	**3—A lot**	**4—Extremely**
I've reduced or discontinued my activities					
I spend a lot of time each day sitting or lying down					
I don't do a lot of tasks I used to do					
I've lost physical conditioning					
I use my body differently in order to avoid pain					
I've gained weight					
I have a lower pain tolerance					
My muscles are weaker					
I'm less flexible					
I have less energy					
My sleep is disturbed					
I feel more physically vulnerable					
I've lost physical confidence					
I've lost valued roles					
My self-image is diminished					
My physical identity has been lost					
I feel less confident					
I feel less capable					
I feel less competent					
I've lost physical comfort					
I feel less safe and secure					
I've become more dependent on others					
I've become more fearful of mortality					
I find dealing with my pain to be physically draining					
I feel diminished in others' eyes					

A-3. Emotional and Psychological Impacts Inventory

Read each statement. Check (√) the column that indicates how true you believe that statement to be OVERALL. Please address all the items.

My experience overall is that ...	0—Not at all	1—Somewhat	2—Moderately	3—A lot	4—Extremely
I've lost physical identity					
I've lost self-image					
I've lost self-worth					
I've lost self-confidence					
I've lost self-acceptance					
I've lost social acceptance and inclusion					
I think others have negative perceptions of me					
I have more self-doubt					
I see myself as disabled					
I see myself as a patient or a diagnosis, not a person					
I've lost a sense of belonging					
I have a negative body image					
I feel marginalized					
I feel discriminated against					
I avoid difficult challenges					
I cannot engage in daily activities					
I cannot complete activities of daily living (e.g., bathing, brushing teeth, dressing)					
I cannot use proper body mechanics					
I use a prosthetic device (e.g., cane, back brace, walker, crutches)					

A-4. Physical Impacts Checklist

Read each statement. Check (√) all items that apply to your pain experience.

√	
	I experience significant pain (many hours per day)
	I experience pain at all times of day
	I experience pain in multiple physical areas of my body
	I experience pain at a disturbing and concerning level (6–10 on a scale of 0–10)
	Pain has significantly affected my ability to get things done
	Pain has caused significant sleep disruption (multiple awakenings related to pain, non-restful and fitful sleep)
	Certain activities immediately causes pain (bending, lifting, coughing, sneezing)
	I experience pain at a moderate to more severe level
	My condition is worse now than at the time of my original treatment
	My condition is worsening over time
	I have no positive expectations for pain reductions in the future
	I spend an excessive amount of time sitting or lying down
	I change my position frequently
	I avoid doing household chores
	I have difficulty dressing
	I use handrails and other supports when moving around
	My pain interferes with activities
	I walk more slowly
	I find it difficult to stand up
	I get dressed more slowly
	I am aware of pain during the majority of the day and night
	Guarding and protecting behaviors – (avoids certain movements, tries not to bend or kneel, lies sideways in bed, sits sideways to dress, lifts with the left side)
	I've lost the ability to do certain activities
	I've lost the ability to do certain tasks
	I'm unable to do my favorite tasks or activities
	I use a potentially addictive medication
	My medications cause side effects that undermine functioning

	I've lost physical conditioning
	I've lost athleticism
	This is my first physical injury
	I am physically weaker, with less flexible muscles and less energy
	I've gained weight
	I have new physical problems related to my medications
	I've lost physical identity
	I've lost physical competence
	I've lost physical confidence
	I am more physically dependent on others
	I've lost physical self-image
	I've lost physical strength and confidence
	I feel unrelenting pain and discomfort
	My pain is unpredictable, with no patterns or control of flare-ups
	I am dependent on medication

Appendix B

Personal Impacts Assessments

The questionnaires in this section correspond with Part 3 of the book (Chapters 11 – 16)

B-1. Personal Experience Inventory

Read each statement. Check (√) the column that indicates how true you believe that statement to be SINCE YOUR INJURY OR ILLNESS. Please address all the items.

The pain from my injury or illness has ...	**0—Not at all**	**1—Somewhat**	**2—Moderately**	**3—A lot**	**4—Extremely**
Impacted my lifestyle					
Reduced my pleasure and/or satisfaction in life					
Limited my opportunities					
Changed my social and economic status					
Changed my expectations					
Undermined my capacity to enjoy life					
Changed my pursuits					
Led to the loss of satisfying social activities					
Undermined my ability to take good care of myself					
Undermined my sense of well-being					
Interfered with me learning new things					
Interfered with me having new and satisfying experiences					
Reduced my ability to feel productive					
Limited my potential or ability to sustain effort					
Affected my memory, concentration, attention, and/or focus					
Led to loss of relationships					
Made me feel alienated from others					
Damaged my relationships					
Undermined my ability to cope					
Made me feel insecure					
Made me feel ashamed of myself					
Made it hard for me to be the person I want to be					
Made me less confident					

	0	1	2	3	4
Made me less competent					
Caused emotional or psychological problems					
Made me feel like I'm not myself					
Gotten in the way of the way I want my life to be					
Made me lose or change roles					
Made me feel too dependent on others					
Made me develop negative beliefs about pain					
Made me fearful of pain					
Made me fearful of engaging in most activity of any kind					
Made me fearful of re-injuring myself					
Made me fearful of rehabilitation					
Convinced me I'm disabled					
Made me preoccupied with my pain					
Made me fearful of mortality					

B-2. Personal Impacts Checklist

Read each statement. Check (√) all items that apply to your pain experience.

PERSONAL MEANING **Since my injury or illness ...**	
	I've experienced major impacts to my life
	I've experienced breakdowns in coping abilities
	I've experienced loss of personal style
	I've experienced loss of self-efficacy
	I've experienced dysfunctional, negative thoughts or self-talk
	I've had repeated thoughts of past negative experiences that involved feeling victimized and helpless
	I've developed a pain phobia
	I've felt that my failure to recover is a personal failure
	I've had repeated thoughts of past trauma
	I've had repeated thoughts of past injury or pain
	I've felt diminished as a person
	I've felt that I'm paying for life with pain
	I have fear of the future
PERSONAL IDENTITY **Since my injury or illness ...**	
	I've felt disconnected from my sense of a past or future self
	I've experienced loss of autonomy
	I've failed to fulfill important roles, such as spouse, parent, provider, friend, or worker
	I've experienced relationship instability
	I've experienced dysfunctional beliefs
	I've experienced motional instability
	I've experienced breakdowns in problem-solving abilities
	I've experienced breakdowns in following or succeeding with treatment
	I've experienced chronic stress
	I've developed negative pain beliefs

	PERSONAL DEVELOPMENT **During my childhood ...**
	I did not feel taken care of
	I experienced abuse/neglect
	I did not feel privileged
	I experienced emotional enmeshment (e.g., unclear personal boundaries between myself and others)
	I experienced childhood trauma
	I experienced parental injury, illness, unhappiness
	I experienced family instability
	I was expected to play a parental role

B-3. Risk Factors for Injury Inventory

Read each statement. Check (√) the column that indicates how true you believe that statement to be ABOUT YOUR CHILDHOOD AND LIFE EXPERIENCES. Please address all the items.

During my childhood ...	**0—Not at all**	**1—Somewhat**	**2—Moderately**	**3—A lot**	**4—Extremely**
I experienced abandonment by a parent or other significant family member					
My parents divorced					
One or both of my parents was harsh, punitive, distant, or cold					
I experienced physical abuse					
I experienced sexual abuse					
I experienced emotional abuse					
I experienced neglect					
I experienced trauma					
I was expected to play a "parent" role					
There was a lot of interpersonal conflict in the household					
I experienced significant loss					
One or both of my parents engaged in substance abuse					
One or both of my parents suffered from chronic illness or injury					
I suffered from chronic illness or injury					
I experienced special value for being sick					
One or both of my parents paid excessive attention to or worried over physical problems					
A member of my household was disabled					
A member of my household was unable to leave the house					
The time my chronic pain began was the first time I was injured					
There seemed to be no relationship between my pain and my diagnosed injury					

	0	1	2	3	4
I was diagnosed with depression					
I was diagnosed with hypochondria					
I was diagnosed with an anxiety disorder					
I was diagnosed with schizophrenia					
I was diagnosed with a dissociative disorder					
I repressed my emotions					
I saw myself as a victim					
I had problems trusting people					
I had a very limited social life					
I placed a great deal of value on self-sacrifice					

B-4. Social-Emotional Impacts Checklist

Read each statement. Check (√) all items that apply to your pain experience.

√	
	I feel traumatized by my pain
	I've lost connections, relationships, and social activities with friends and family
	I lack exercise
	I experience social isolation
	I worry over my health
	I'm uncertain about how much I can recover
	I'm uncertain about how safe I am physically
	I experience anxiety
	I experience anger
	I experience depression
	I experience excessive worry or frustration
	I experience significant loss of motivation
	I experience increased dependence
	I experience increased vulnerability
	I experience increased fear of mortality
	I have become cynical, judgmental, or mistrusting
	Reduced pleasure and satisfaction in life
	Changed expectations
	I've lost opportunities
	I've lost pleasurable pursuits
	My socioeconomic status has changed
	Undermined self-care and self-image
	I've lost my sense of well-being
	Challenge to the possibility of success
	I've lost important roles
	I feel unhappy
	I feel unsatisfied
	I feel unproductive
	I feel unrewarded
	I feel unaccomplished

	I've lost a sense of fun
	I've lost a sense of playfulness
	I've lost a sense of joy
	I've lost a sense of safety and security
	I've lost a sense of hope and optimism
	I've lost a sense of self-efficacy
	Failure of coping system lost stoicism, keeping negative feelings to self,
	I've lost a sense of being independent
	I've lost a sense of patience
	I've lost a sense of peace
	I've lost a sense of spirituality
	I've lost a sense of autonomy
	I've lost the feeling of being worthwhile, respectable, or likable
	I feel guilt and shame
	I blame myself
	I feel a sense of alienation
	I'm afraid of pain
	I'm afraid of pain permanence
	I'm afraid injuring myself again
	I'm afraid of flare-ups of pain or injury
	I'm afraid of activity
	I'm afraid of disability
	I'm afraid of mortality
	I'm afraid of being weak
	I'm afraid of being disabled
	I feel fragile
	I'm afraid my treatment outcomes will be limited and not complete
	I'm afraid my pain will cause excessive functional impact
	I'm afraid my pain will never stop
	I experience fears of the future
	I have post-traumatic stress disorder

Appendix C

Treatment Experience Assessments

The questionnaires in this section correspond with Part 4 of the book (Chapters 18– 19))

C-1. Treatment Confusion Inventory

Read each statement. Check (√) the column that indicates how true you believe that statement to be TODAY. Please address all the items.

My experience today is that ...	**0—Not at all**	**1—Somewhat**	**2—Moderately**	**3—A lot**	**4—Extremely**
I'm confused about my actual diagnosis—it's ambiguous, indefinite, confusing, and/or contradictory					
My treatment has failed, and I don't really understand why					
My expectations about getting a clear diagnosis have been disappointed					
My treatment has not been managed, coordinated, or integrated					
I've been sent from specialist to specialist in a manner that doesn't improve my condition and adds to my confusion					
I've been damaged further by my treatment					
My treatment experience has made me fearful of treatment					
My treatment has created a dependence on medication					
I'm tired of treatment					
I don't know why I'm in pain					
I don't know what my treatments are for or why					
I don't know which treatment works or doesn't work					
I don't have a coherent, comprehensive, and integrated plan of treatment					
I don't know who is in charge of my treatment					
I don't know if all my providers are on the same team					
I don't know why my providers can't seem to diagnose my condition					
I don't know why my providers can't come up with a treatment that works					
I don't know what it means when my treatment doesn't work					

	0	1	2	3	4
I don't know why my providers can't tell me what's going to happen					
I don't know if I've found the right provider					
I don't know how much of my life history my providers need to know to understand my needs					

C-2. Treatment Experience Inventory

Read each statement. Check (√) the column that indicates how true you believe that statement to be SINCE YOUR ILLNESS OR INJURY. Please address all the items.

Since my injury or illness, my experience is that ...	**0—Not at all**	**1—Somewhat**	**2—Moderately**	**3—A lot**	**4—Extremely**
My providers and I really understand each other					
I believe my providers and I are in this together					
I believe my providers and I communicate really well					
I know what my role is in my treatment					
I know what questions to ask my providers					
I know how much of my needs I should talk about with my providers					
My providers and I have shared concepts about my problem					
My providers and I have a strong partnership					
My providers and I are fully prepared for our encounters					
My providers and I clearly and completely express our needs					
My providers and I express both positive and negative reactions to our encounters					
I clearly understand both my role as a patient and my providers' role in my treatment					
My providers share with me all the important and crucial information about my condition					
I share with my providers all the important and crucial information about my condition					
My providers ask me all their most important questions, and I answer					
I ask my providers all my most important questions, and they answer					
My providers clearly diagnose my condition in a way I understand					
My providers offer concrete, positive, understandable treatment plans					

	0	1	2	3	4
My providers meet my treatment needs					
My providers communicate well					
My providers educate me about my condition					
My providers tell me what to do to help my condition in a comprehensive and understandable fashion					
My providers understand my suffering and my need for relief					
My providers make me feel well cared for					

Which of your individual providers would score high on this scale?

C-3. Treatment Visit Evaluation Inventory

Read each statement. Check (√) the column that indicates how true you believe that statement to be AT YOUR MOST RECENT MEDICAL APPOINTMENT. Please address all the items.

At my last appointment, my experience is that ...	**0—Not at all**	**1—Somewhat**	**2—Moderately**	**3—A lot**	**4—Extremely**
I had enough time at my appointment to get what I needed					
I never felt rushed					
I felt I had my provider's full attention					
I felt my provider was sufficiently knowledgeable about my condition					
I felt my provider was respectful					
I felt my provider carefully listened to me and my concerns					
My provider demonstrated as much concern for how I feel about my condition as they did about my physical condition					
My provider asked enough questions to ascertain how my physical condition is affecting my life					
My provider gave me enough information about my condition, treatments, studies, referrals, and expectations					