

Dear Omega **“Your Brain Without Pain”** participant,

We are looking forward to teaching you methods that will enable you to stimulate your brain to grow new neurological pathways that create “detours” around your pain pathways. As your nervous system shifts into these alternate circuits the pain pathways become less active resulting in much less or no pain. With full engagement the results are consistent. We would like to provide you with these questions to enable you to look at your pain now and then re-answer these questions in a year to see how far you have come. This information will not be shared or used to make any treatment decisions. The questions apply to how your overall pain limits you regardless of where it is or how many parts of your body are affected.

Please read the questions carefully and return your completed form by:

Mail:  
Omega Institute for Holistic Studies  
Attn: Registration Dept  
150 Lake Drive  
Rhinebeck, NY 12572

Or scan and email:  
classapplications@eOmega.org

### **Pain Severity**

**1. If 10 is the worst pain imaginable, and 0 is no pain, please note your pain over the last TWO WEEKS:**

a) Please rate your WORST pain.	0	1	2	3	4	5	6	7	8	9	10
b) Please rate your LEAST pain.	0	1	2	3	4	5	6	7	8	9	10
c) Please rate your overall or AVERAGE pain.	0	1	2	3	4	5	6	7	8	9	10

**2. Over the last month, how many days per week have you had your usual pain?**

0 1 2 3 4 5 6 7

### **Function**

**1. Pain intensity** (mark only one)

- I can tolerate the pain I have without having to use pain killers
- The pain is bad but I manage without taking painkillers
- Painkillers give complete relief from pain
- Painkillers give moderate relief from pain
- Painkillers give very little relief from pain
- Painkillers have no effect on the pain, I do not use them

**2. Personal Care (washing, dressing, etc.)** (mark only one)

- I can look after myself normally without it causing extra pain.
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but manage most of my personal care

- I need some help everyday in most aspects of self-care.
- I do not get dressed, wash with difficulty, and stay in bed

3. **Lifting** (mark only one)

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives me extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table)
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can lift only very light weights
- I cannot lift or carry anything at all

4. **Walking** (mark only one)

- Pain does not prevent me from walking any distance
- Pain prevents me walking more than 1 mile
- Pain prevents me walking more than ½ mile
- Pain prevents me walking more than ¼ mile
- I can only walk using a stick or crutches
- I am in bed most of the time and have to crawl to the toilet

5. **Sitting** (mark only one)

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than one hour
- Pain prevents me from sitting more than thirty minutes
- Pain prevents me from sitting more than ten minutes
- Pain prevents me from sitting at all

6. **Standing** (mark only one)

- I can stand as long as I want without extra pain
- I can stand as long as I want but it causes extra pain
- Pain prevents me from standing more than one hour
- Pain prevents me from standing more than thirty minutes
- Pain prevents me from standing more than ten minutes
- Pain prevents me from standing at all

7. **Sleeping** (mark only one)

- Pain does not prevent me from sleeping well
- I can sleep well only by using tablets
- Even when I take tablets I have less than six hours of sleep
- Even when I take tablets I have less than four hours of sleep
- Even when I take tablets I have less than two hours of sleep
- Pain prevents me from sleeping at all

8. **Employment/Homemaking** (mark only one)

- My normal homemaking/job activities do not cause pain
- My normal homemaking/job activities increase my pain, but I can still perform all that is required of me
- I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming)
- Pain prevents me from doing anything but light duties
- Pain prevents me from doing even light duties
- Pain prevents me from performing any job or homemaking chores

9. **Social Life** (mark only one)

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.)
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to home
- I have no social life because of pain

10. **Traveling** (mark only one)

- I can travel anywhere without extra pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys less than one hour
- Pain restricts me to short journeys less than thirty minutes
- Pain prevents me from traveling except to the doctor or hospital

**Social / Environmental History:**

**Education:**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| High school diploma                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| GED   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Did not complete high school or receive a GED | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

What is your highest level of education or training? \_\_\_\_\_

Are you Fluent in English?  Yes  No Other language \_\_\_\_\_

**Marital Status:**

What is your marital status?  Married/Partner  Divorced/Separated  Single  Widowed

Have you had a stress or change in a significant relationship within the past 12 months?  Yes  No

If yes, please explain:

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What are the ages of your children?

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**Sleep:**

Have you had any of these sleep problems at least half the days of the past month?

- Trouble falling asleep when you first go to bed  Yes  No
- Waking up during the night and not easily going back to sleep  Yes  No
- Waking up in the morning earlier than planned or desired  Yes  No
- Feeling unsatisfied or not rested by your night's sleep  Yes  No
- Feeling excessively sleepy during the day (does not include regular naps)  Yes  No

How many hours per night do you sleep currently, on average? \_\_\_\_\_

Did your sleep problems exist prior to your current pain problem?  Yes  No  No sleep problems now

**Mood:**

*These questions are about how you feel and how things have been with you **during the past four weeks**. For each question, please give one answer that comes closest to the way you have been feeling.*

Do you feel you might be depressed or overly anxious?  Yes  No

Circle the appropriate number to indicate the extent of the problem you are having with each of the following:

	NONE										SEVERE		
Anxiety	0	1	2	3	4	5	6	7	8	9	10		
Depression	0	1	2	3	4	5	6	7	8	9	10		
Irritability	0	1	2	3	4	5	6	7	8	9	10		

Have you ever considered yourself a victim of physical, emotional or sexual abuse? Yes No

Are you receiving care from a mental health professional?  Yes  No

If yes, please explain \_\_\_\_\_

**Occupational History:**

Employer: \_\_\_\_\_ Date of hire: \_\_\_\_\_ Usual occupation: \_\_\_\_\_

Briefly describe your job: \_\_\_\_\_

1. How physically demanding is your job?

- Very heavy (frequently lifting over 50 pounds)  Light (frequently lifting under 10 pounds)
- Heavy (frequently lifting 25-50 pounds)  Sedentary (essentially no lifting)
- Moderate (frequently lifting 10- 25 pounds)

2. Work status at the **TIME OF ONSET** of this episode of back/neck pain:

- Regular: full time  Retired

- |   |   |
|---|---|
| <input type="checkbox"/> Regular: part time                           | <input type="checkbox"/> On public assistance                 |
| <input type="checkbox"/> Working modified job (e.g., light duty)      | <input type="checkbox"/> Permanent disability (pension, SSDI) |
| <input type="checkbox"/> Not currently in workforce/homemaker/student | <input type="checkbox"/> Other_____                           |
| <input type="checkbox"/> Unemployed, looking for work                 |   |

3. Work status **TODAY**

- |   |   |
|---|---|
| <input type="checkbox"/> Regular: full time                                 | <input type="checkbox"/> Retired                              |
| <input type="checkbox"/> Regular: part time                                 | <input type="checkbox"/> On public assistance                 |
| <input type="checkbox"/> Working modified job (e.g., light duty)            | <input type="checkbox"/> Permanent disability (pension, SSDI) |
| <input type="checkbox"/> On active disability time loss                     |   |
| <input type="checkbox"/> Not currently in workforce(i.e. homemaker/student) | <input type="checkbox"/> Other_____                           |
| <input type="checkbox"/> Unemployed, looking for work                       |   |

4. How satisfied are/were you with your job?

- Very satisfied    Satisfied    Dissatisfied    Worst job I've ever had    N/A

5. How certain are you that you will be working in 6 months? (circle one)

0   1   2   3   4   5   6   7   8   9   10  
 Not at all                      Certain                      Definitely

6. When do you expect to return to work?

- Next 2 weeks    2-6 weeks    6-12 weeks    3-6 months    > 6 months    never    N/A

7. Are you planning to apply for permanent disability such as Social Security Disability (SSDI) or other permanent disability? (e.g., worker's compensation, pension)    Yes    No

8. Has your employer treated you fairly?

- Yes    No    N/A   If no, please explain:

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**Personal Information:**

Your Name: \_\_\_\_\_

Preferred email: \_\_\_\_\_

Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

How did you learn about this workshop? \_\_\_\_\_  
\_\_\_\_\_

How long have you been experiencing chronic pain? \_\_\_\_\_

How long has it significantly affected your quality of life? \_\_\_\_\_

Please list your three worst areas/types of chronic pain:

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

What is the impact of chronic pain on the quality of your life over the last year?

1 2 3 4 5 6 7 8 9 10  
no effect moderate extreme impact

What do you think your chances are of getting rid of your chronic pain within the next 12 months?

1 2 3 4 5 6 7 8 9 10  
no chance hopeful optimistic

In addition to getting rid of your chronic pain what other benefits would you like to receive from this week?

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How open are you to learning new treatment concepts based on the Mind Body Syndrome principles (MBS)?

1 2 3 4 5 6 7 8 9 10  
cynical somewhat open enthusiastic

Is there anything else that you would like us to know about you?

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Do you have particular talents or areas of expertise such as music, art, performance, dance, story telling, etc.?

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

Are there any of the above that you would like to share with the group during the week? We will only ask if you are open. We will not twist your arm. You also don't have to be a professional. If you have an instrument you play that is easy to carry we would encourage you to bring it.

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

**Writing:**

Pain pathways are permanent. The harder you try to get rid of them the less success you will have. It is similar to trying to unlearn riding a bicycle. The basic principle of this seminar is creating new neurological pathways around your old circuits. There are three parts to it: 1) awareness 2) detachment 3) reprogramming. This sequence is critical. The seminar will be focused on step 3 – reprogramming. One of the most effective re-programming tools is play in almost any form.

We are asking you to engage in steps one and two prior to coming to the seminar. The most effective way is actively engaging in the writing exercises described on the website, [www.back-in-control.com](http://www.back-in-control.com). On the bottom of the home page under “Getting Started” you will notice #3 – “Start Writing Now”. You cannot control your thoughts but you can separate from them.

We are asking you to begin the process of writing down your negative thoughts and instantly throwing them away. With the writing you are becoming aware of the disruptive thoughts around your pain and detaching from them in form of the space between you and the paper. This space is now connected with vision and feel. You have begun to form new pathways. Your healing will not begin until you engage in this step.

The writing exercise is not the final solution for your pain but it is the foundation of the whole process. It is not quite as easy as you might think. Every patient initially resists this step. He or she cannot believe that they have these thoughts in their head. However within two to four weeks after engaging in this step most people will sense a perceptible shift in their consciousness.

If you cannot get yourself to engage in this step then you should re-think attending this seminar. You are not ready for it at this time. There is no way around the permanency of the pain pathways and this exercise is critical.

## **Do You Have Mind Body Syndrome?**

Dr. Howard Schubiner is a friend of mine who is a pain specialist practicing in Detroit who has tremendous expertise in the Mind Body Syndrome. He trained with Dr. John Sarno who originally described it in the 1980's. He wrote a book, "Unlearn Your Pain". In his chapter 5 he gives the following list of MBS symptoms. I wrote a website post, "My Struggle with MBS". I experienced 16 of his 33 listed symptoms. You will find it enlightening to systematically go through his list and see how many you are dealing with.

### **"Unlearn Your Pain"**

This section is an excerpt from Dr. Howard Schubiner's book, "Unlearn Your Pain"

## **Mind Body Syndrome Self-Diagnosis**

To figure out if you have MBS and what issues in your life may have contributed to this disorder, take the time to complete the work sheets below. They will help you understand yourself better, and this understanding is the key to ridding yourself of your pain. This section is based upon the detailed interview I use with my patients.

### **STEP 1: SYMPTOMS**

The following list of symptoms and diagnoses are likely to be caused by MBS (though some of them can also be caused by other medical conditions that can be easily ruled out by your physician). The more of these you have had during your lifetime, the more likely it is that you have MBS. People with several of these conditions have usually seen many doctors and been given multiple diagnoses, but their doctors have not considered MBS. This is because biotechnological medical practice tends to look at each body system in isolation. You may have seen a neurologist, orthopedic surgeon or neurosurgeon, gastroenterologist, rheumatologist, or others. But no one is looking at the whole person. MBS occurs in people, not in body parts, and we can only understand it by evaluating the whole person, the mind, and the body.

It is very common for MBS symptoms to start in childhood or adolescence. Many people develop headaches, stomach aches, dizziness, fatigue, anxiety, or other symptoms while they are young and then later in life develop back or neck pain, fibromyalgia, irritable bowel syndrome, or other conditions.

CHECK EACH ITEM ON THIS LIST and write down at what age you were when each set of symptoms first appeared in your life.

#### **Date of onset:**

1. Heartburn, acid reflux \_\_\_\_\_
2. Abdominal pains \_\_\_\_\_

3. Irritable bowel syndrome \_\_\_\_\_
4. Tension headaches \_\_\_\_\_
5. Migraine headaches \_\_\_\_\_
6. Unexplained rashes \_\_\_\_\_
7. Anxiety and/or panic attacks \_\_\_\_\_
8. Depression \_\_\_\_\_
9. Obsessive-compulsive thought patterns \_\_\_\_\_
10. Eating disorders \_\_\_\_\_
11. Insomnia or trouble sleeping \_\_\_\_\_
12. Fibromyalgia \_\_\_\_\_
13. Back pain \_\_\_\_\_
14. Neck pain \_\_\_\_\_
15. Shoulder pain \_\_\_\_\_
16. Repetitive stress injury \_\_\_\_\_
17. Carpal tunnel syndrome \_\_\_\_\_
18. Reflex sympathetic dystrophy (RSD) \_\_\_\_\_
19. Temporomandibular joint syndrome (TMJ) \_\_\_\_\_
20. Chronic tendonitis \_\_\_\_\_
21. Facial pain \_\_\_\_\_
22. Numbness, tingling sensations \_\_\_\_\_
23. Fatigue or chronic fatigue syndrome \_\_\_\_\_
24. Palpitations \_\_\_\_\_
25. Chest pain \_\_\_\_\_
26. Hyperventilation \_\_\_\_\_
27. Interstitial cystitis/spastic bladder (irritable bladder syndrome) \_\_\_\_\_
28. Pelvic pain \_\_\_\_\_
29. Muscle tenderness \_\_\_\_\_
30. Postural orthostatic tachycardia syndrome (POTS) \_\_\_\_\_
31. Tinnitus \_\_\_\_\_
32. Dizziness \_\_\_\_\_
33. PTSD \_\_\_\_\_

We will also be curious to know how many of these symptoms you have had resolve by the time you attend the seminar. With full engagement with “Back in Control: A Spine Surgeon’s Roadmap Out of Chronic Pain” and the website, [www.back-in-control.com](http://www.back-in-control.com) many of you will have already experienced significant relief. This is a self-directed process.

We have enjoyed watching many people take their lives back.

To a rich and full life,

David Hanscom, M.D.  
 Fred Luskin, PhD  
 Babs Yohai