Baseline Patient Survey

Thank you for participating in the BESI-C research project! Please answer the following questions to the best of your ability.

Please mark the response that best matches your experience.

Because we are interested in your individual perspective, please answer these questions independently (separate from your partner).

Question	Response
On a day-to-day basis, who is generally most responsible for managing and keeping track of your pain medication(s)?	◯ Me, as the patient ◯ My caregiver ◯ Both of us; we equally manage my pain medication(s).
How confident are you in managing your pain?	◯ Not at all ◯ A little ◯ Somewhat ◯ Quite ◯ Very ◯ I don't know
How effective, overall, do you think your current pain regimen is at controlling your pain?	◯ Not at all ◯ A little ◯ Somewhat ◯ Quite ◯ Very ◯ I don't know
How much does pain interfere with your day-to-day activities?	◯ Not at all ◯ A little ◯ Somewhat ◯ Quite ◯ Very ◯ I don't know
Select the statement that best describes you today.	◯ I am fully active. ◯ I can't do heavy work, but I can do some light work. ◯ I can't do any work, but I can care for myself. ◯ I need some help caring for myself, and I spend most of the day in bed or in a chair. ◯ I need much help caring for myself and I spend nearly all day in bed or in a chair.

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Please help us understand more about your cancer pain.

Do you have some amount of cancer pain all the time/constantly?	◯ Yes ◯ No ◯ Unsure
What is your average constant pain level?	◯ 0 (No pain) ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 (Worst pain)
How often do you have acute/sudden cancer pain events?	◯ Never ◯ 1-4 times/day ◯ 5 - 8 times/day ◯ More than 8 times/day ◯ Unsure
What is your average acute pain level?	◯ 0 (No pain) ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 (Worst pain)
What is your pain level right now?	◯ 0 (No pain) ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 (Worst pain)
Where do you experience most of your cancer pain?	◯ Head/Neck ◯ Chest ◯ Back ◯ Leg(s) ◯ Arm(s) ◯ Stomach ◯ All over ◯ Other
Please specify the "other" location of your cancer pain.	__________________________________

Do the following help relieve your pain?

	Yes	No	I haven't tried this
Over the counter creams or ointments	◯	◯	◯
Ice/Heat	◯	◯	◯
Massage	◯	◯	◯
Exercise/activity/walking	◯	◯	◯
Listening to music/watching T.V.	◯	◯	◯
Comfortable or special position	◯	◯	◯
Being with other people	◯	◯	◯
Resting/sleep	◯	◯	◯
Progressive muscle relaxation/taking deep breaths	◯	◯	◯
Guided imagery/hypnosis	◯	◯	◯
Acupuncture/acupressure	◯	◯	◯
Prayer/Meditation	◯	◯	◯
Distracting activity, like sewing or handiwork	◯	◯	◯
Other	◯	◯	◯

Please specify what other activity helps your pain.

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Do you have any of the following common medical problems?

Do you have heart disease?	◯ Yes ◯ No
Do you receive treatment for heart disease?	◯ Yes ◯ No
Does heart disease limit your activities?	◯ Yes ◯ No
Do you have lung disease?	◯ Yes ◯ No
Do you receive treatment for lung disease?	◯ Yes ◯ No
Does lung disease limit your activities?	◯ Yes ◯ No
Do you have diabetes?	◯ Yes ◯ No
Do you receive treatment for diabetes?	◯ Yes ◯ No
Does diabetes limit your activities?	◯ Yes ◯ No
Do you have kidney disease?	◯ Yes ◯ No
Do you receive treatment for kidney disease?	◯ Yes ◯ No
Does kidney disease limit your activities?	◯ Yes ◯ No
Do you have liver disease?	◯ Yes ◯ No
Do you receive treatment for liver disease?	◯ Yes ◯ No
Does liver disease limit your activities?	◯ Yes ◯ No
Do you have ulcer or stomach disease?	◯ Yes ◯ No
Do you receive treatment for ulcer or stomach disease?	◯ Yes ◯ No
Does ulcer or stomach disease limit your activities?	◯ Yes ◯ No
Do you have depression or anxiety?	◯ Yes ◯ No

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Question	Response
Do you receive treatment for depression or anxiety?	◯ Yes ◯ No
Does depression or anxiety limit your activities?	◯ Yes ◯ No

Question	Response
Do you have rheumatoid arthritis?	◯ Yes ◯ No
Do you receive treatment for rheumatoid arthritis?	◯ Yes ◯ No
Does rheumatoid arthritis limit your activities?	◯ Yes ◯ No

Question	Response
Do you have osteoarthritis?	◯ Yes ◯ No
Do you receive treatment for osteoarthritis?	◯ Yes ◯ No
Does osteoarthritis limit your activities?	◯ Yes ◯ No

Question	Response
Do you have other chronic pain (separate from your cancer pain)?	◯ Yes ◯ No
Do you receive treatment for other chronic pain (separate from your cancer pain)?	◯ Yes ◯ No
Does other chronic pain (separate from your cancer pain) limit your activities?	◯ Yes ◯ No

Question	Response
Do you have a neurological disease (like Multiple Sclerosis)?	◯ Yes ◯ No
Do you receive treatment for a neurological disease (like Multiple Sclerosis)?	◯ Yes ◯ No
Does a neurological disease (like Multiple Sclerosis) limit your activities?	◯ Yes ◯ No

Question	Response
Do you have other medical problems?	◯ Yes ◯ No
Please specify your other medical problem(s).	__________________________________
Do you receive treatment for your other medical problem(s)?	◯ Yes ◯ No

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Do your other medical problems limit your activities? ◯ Yes ◯ No

Please tell us about your COVID-19 experience.

Have you ever had COVID-19?

- ◯ Yes
- ◯ No
- ◯ Unsure
- ◯ Prefer not to answer

When did you have COVID-19?

- ◯ Less than 1 month ago
- ◯ 1-3 months ago
- ◯ 4-6 months ago
- ◯ More than 6 months ago
- ◯ Prefer not to answer

Do you continue to feel bad from COVID-19?

- ◯ Yes
- ◯ No
- ◯ Unsure
- ◯ Prefer not to answer

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