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Appendix a: General data

General data

- What is your year of birth?
- What is your gender? male/female
- What is your length ? _____ cm
- What is your weight ? _____ kg

- What country were you born in? _____
- What country(ies) were your parents born in? _____
- What country(ies) were your grandparents born in? _____
- What human race are you? (black, white, Asian, etc.) _____

Data of the surgery:

- *Would you please describe your surgery:*

- How much pain do you expect after surgery (0= no pain, 10=worst pain imaginable)
- Will you stay one or more nights in the hospital after surgery? Yes / No

Appendix b: Pain before and after surgery

Pain before and after surgery

Circle how much pain you have, expressed as a number. The pain score means a score between 0 and 10, where 0 means no pain and 10 means the worst pain imaginable. For your pain, consider a figure between 0 and 10. You also tick whether you think the pain is acceptable or not.

Pain while being at rest at this moment (0-10)	No pain 0-1-2-3-4-5-6-7-8-9-10 worst pain imaginable
Pain score at this moment if you perform a normal effort (0-10)	No pain 0-1-2-3-4-5-6-7-8-9-10 worst pain imaginable
Do you think pain is acceptable to you at this moment?	Pain acceptable __ pain not acceptable __
Only pre-operatively: How much pain do you expect after surgery?	No pain 0-1-2-3-4-5-6-7-8-9-10 worst pain imaginable

Appendix c: Physical activities

Physical activities

Circle the one number below that best describes how much, since your surgery, pain interfered with or prevented you from doing physical activities, expressed by figure. The score means a figure between 0 and 10, where 0 means no interference and 10 means complete interference.

1. How much has pain interfered with or prevented you from doing activities in bed such as turning, sitting up, changing position (0= did not interfere, 10= completely interfered)

0-1-2-3-4-5-6-7-8-9-10

2. How much has pain interfered with or prevented you from breathing deeply or coughing (0= did not interfere, 10= completely interfered)

0-1-2-3-4-5-6-7-8-9-10

3. How much has pain interfered with or prevented you from sleeping (0= did not interfere, 10= completely interfered)

0-1-2-3-4-5-6-7-8-9-10

4. Have you been out of bed since your surgery?

Yes/no

5. If yes, how much did pain interfere or prevent you from doing activities out of bed such as walking, sitting in a chair, standing at the sink (0= did not interfere, 10= completely interfered)

0-1-2-3-4-5-6-7-8-9-10

Appendix d: Pain disability index

Pain disability index

We would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

In case of no pain, please circle "0".

<p>1. Family/Home Responsibilities</p> <p>This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).</p>	<p>No disability 0-1-2-3-4-5-6-7-8-9-10 Worst disability</p>
<p>2. Recreation</p> <p>This disability includes hobbies, sports, and other similar leisure time activities.</p>	<p>No disability 0-1-2-3-4-5-6-7-8-9-10 Worst disability</p>
<p>3. Social activity</p> <p>This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.</p>	<p>No disability 0-1-2-3-4-5-6-7-8-9-10 Worst disability</p>
<p>4. Occupation</p> <p>This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.</p>	<p>No disability 0-1-2-3-4-5-6-7-8-9-10 Worst disability</p>
<p>5. Sexual behavior</p> <p>This category refers to the frequency and quality of one's sex life.</p>	<p>No disability 0-1-2-3-4-5-6-7-8-9-10 Worst disability</p>
<p>6. Self care</p>	<p>No disability 0-1-2-3-4-5-6-7-8-9-10 Worst disability</p>

This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)	
7. Life-support activities This category refers to basic life supporting behaviors such as eating, sleeping and breathing.	No disability 0-1-2-3-4-5-6-7-8-9-10 Worst disability

Appendix e: Anxiety and need for information

Anxiety and need for information

Please circle the number on the scale that describes your experience:

The Amsterdam Preoperative Anxiety and Information Scale (APAIS):	Not at all				Extremely
I am worried about the anesthetic	1	2	3	4	5
The anesthetic is on my mind continually	1	2	3	4	5
I am worried about the procedure	1	2	3	4	5
The procedure is on my mind continually	1	2	3	4	5
I would like to know as much as possible about the anesthetic	1	2	3	4	5
I would like to know as much as possible about the procedure	1	2	3	4	5

Appendix f: Pain Catastrophizing Scale (PCS)

Pain Catastrophizing Scale (PCS)

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen 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 are experiencing 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

1.	I worry all the time about whether the pain will end	0	1	2	3	4
2.	I feel I can't go on	0	1	2	3	4
3.	It's terrible and I think that it's never going to get any better	0	1	2	3	4
4.	It's awful and I feel that it overwhelms me	0	1	2	3	4
5.	I feel that I can't stand it any more	0	1	2	3	4
6.	I become afraid that the pain will get worse	0	1	2	3	4
7.	I keep thinking of other painful events	0	1	2	3	4
8.	I anxiously want the pain to go away	0	1	2	3	4
9.	I can't seem to keep it out of my mind	0	1	2	3	4
10.	I keep thinking about how much it hurts	0	1	2	3	4
11.	I keep thinking about how badly I want the pain to stop	0	1	2	3	4
12.	There's nothing I can do to reduce the intensity of the pain	0	1	2	3	4
13.	I wonder whether something serious may happen	0	1	2	3	4

Appendix g: Pain Sensitivity Questionnaire

Pain Sensitivity Questionnaire

This questionnaire contains a series of questions in which you should imagine yourself in certain situations. You should then decide if these situations would be painful for you and if yes, how painful they would be.

Let 0 stand for no pain; 1 is an only just noticeable pain and 10 the most severe pain that you can imagine or consider possible.

Please mark the scale with a cross on the number that is most true for you. Keep in mind that there are no "right" or "wrong" answers; only your personal assessment of the situation counts. Please try as much as possible not to allow your fear or aversion of the imagined situations affect your assessment of painfulness.

1. Imagine you bump your shin badly on a hard edge, for example, on the edge of a glass coffee table. How painful would that be for you?

0 = not at all painful, 10= most severe pain imaginable

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

2. Imagine you burn your tongue on a very hot drink.

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

3. Imagine your muscles are slightly sore as the result of physical activity.

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

4. Imagine you trap your finger in a drawer.

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

5. Imagine you take a shower with lukewarm water.

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

6. Imagine you have mild sunburn on your shoulders.

- 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
7. Imagine you grazed your knee falling off your bicycle.
- 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
8. Imagine you accidentally bite your tongue or cheek badly while eating.
- 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
9. Imagine walking across a cool tiled floor with bare feet.
- 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
10. Imagine you have a minor cut on your finger and inadvertently get lemon juice in the wound.
- 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
11. Imagine you prick your fingertip on the thorn of a rose.
- 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
12. Imagine you stick your bare hands in the snow for a couple of minutes or bring your hands
in contact with snow for some time, for example, while making snowballs.
- 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
13. Imagine you shake hands with someone who has a normal grip.
- 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
14. Imagine you shake hands with someone who has a very strong grip.
- 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
15. Imagine you pick up a hot pot by inadvertently grabbing its equally hot handles.
- 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
16. Imagine you are wearing sandals and someone with heavy boots steps on your foot.
- 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

17. Imagine you bump your elbow on the edge of a table ("funny bone").

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

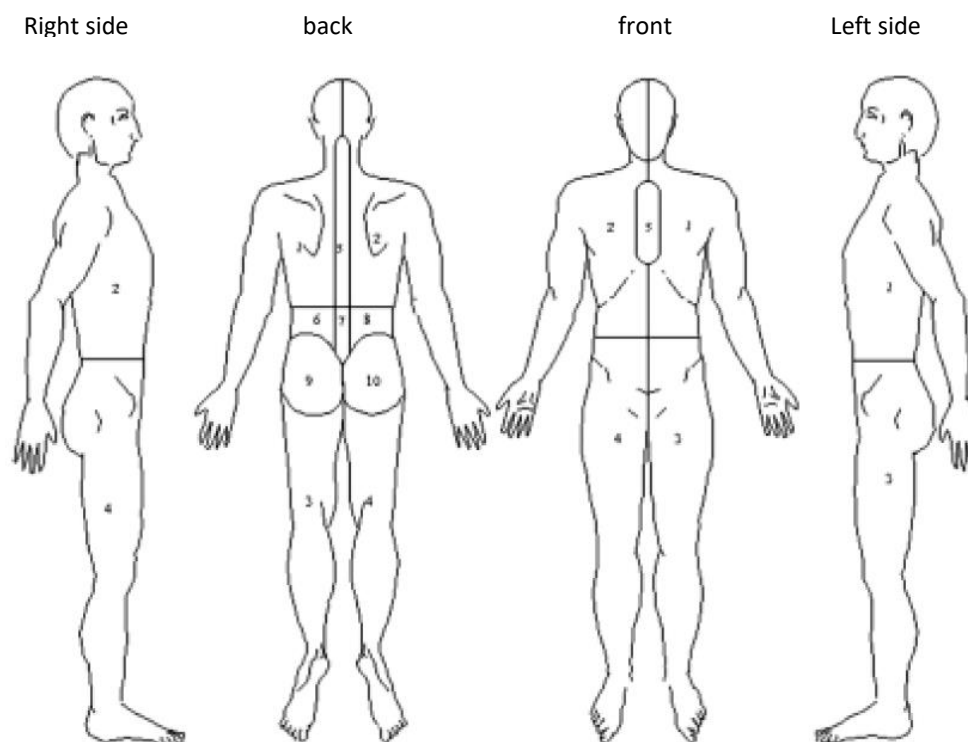
Appendix h: Chronic pain

Chronic pain

Did you experience any pain in the last month that lasted for a day or more?

- Yes, next question
- No

Can you indicate in the drawings below where you suffer (have suffered) from pain?



Is this the same spot as the spot you are operated on? Yes/no

Does the pain differ from the pain before surgery? Yes/no

How long have you been affected by the above-mentioned pain?

- Less than three months
- More than three months

Appendix i: Inventory of depressive symptomatology (self-report) (IDS-SR)

INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT)
(IDS-SR)

NAME: _____ TODAY'S DATE _____

Please circle the one response to each item that best describes you for the past seven days.

1. Falling Asleep:
- 0 I never take longer than 30 minutes to fall asleep.
- 1 I take at least 30 minutes to fall asleep, less than half the time.
- 2 I take at least 30 minutes to fall asleep, more than half the time.
- 3 I take more than 60 minutes to fall asleep, more than half the time.
2. Sleep During the Night:
- 0 I do not wake up at night.
- 1 I have a restless, light sleep with a few brief awakenings each night.
- 2 I wake up at least once a night, but I go back to sleep easily.
- 3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.
3. Waking Up Too Early:
- 0 Most of the time, I awaken no more than 30 minutes before I need to get up.
- 1 More than half the time, I awaken more than 30 minutes before I need to get up.
- 2 I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.
- 3 I awaken at least one hour before I need to, and can't go back to sleep.
4. Sleeping Too Much:
- 0 I sleep no longer than 7-8 hours/night, without napping during the day.
- 1 I sleep no longer than 10 hours in a 24-hour period including naps.
- 2 I sleep no longer than 12 hours in a 24-hour period including naps.
- 3 I sleep longer than 12 hours in a 24-hour period including naps.
5. Feeling Sad:
- 0 I do not feel sad
- 1 I feel sad less than half the time.
- 2 I feel sad more than half the time.
- 3 I feel sad nearly all of the time.
6. Feeling Irritable:
- 0 I do not feel irritable.
- 1 I feel irritable less than half the time.
- 2 I feel irritable more than half the time.
- 3 I feel extremely irritable nearly all of the time.
7. Feeling Anxious or Tense:
- 0 I do not feel anxious or tense.
- 1 I feel anxious (tense) less than half the time.
- 2 I feel anxious (tense) more than half the time.
- 3 I feel extremely anxious (tense) nearly all of the time.
8. Response of Your Mood to Good or Desired Events:
- 0 My mood brightens to a normal level which lasts for several hours when good events occur.
- 1 My mood brightens but I do not feel like my normal self when good events occur.
- 2 My mood brightens only somewhat to a rather limited range of desired events.
- 3 My mood does not brighten at all, even when very good or desired events occur in my life.
9. Mood in Relation to the Time of Day:
- 0 There is no regular relationship between my mood and the time of day.
- 1 My mood often relates to the time of day because of environmental events (e.g., being alone, working).
- 2 In general, my mood is more related to the time of day than to environmental events.
- 3 My mood is clearly and predictably better or worse at a particular time each day.
- 9A. Is your mood typically worse in the morning, afternoon or night? (circle one)
- 9B. Is your mood variation attributed to the environment? (yes or no) (circle one)
10. The Quality of Your Mood:
- 0 The mood (internal feelings) that I experience is very much a normal mood.
- 1 My mood is sad, but this sadness is pretty much like the sad mood I would feel if someone close to me died or left.
- 2 My mood is sad, but this sadness has a rather different quality to it than the sadness I would feel if someone close to me died or left.
- 3 My mood is sad, but this sadness is different from the type of sadness associated with grief or loss.

Please complete either 11 or 12 (not both)

11. Decreased Appetite:

- 0 There is no change in my usual appetite.
- 1 I eat somewhat less often or lesser amounts of food than usual.
- 2 I eat much less than usual and only with personal effort.
- 3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

12. Increased Appetite:

- 0 There is no change from my usual appetite.
- 1 I feel a need to eat more frequently than usual.
- 2 I regularly eat more often and/or greater amounts of food than usual.
- 3 I feel driven to overeat both at mealtime and between meals.

Please complete either 13 or 14 (not both)

13. Decreased Weight (Within the Last Two Weeks):

- 0 I have not had a change in my weight.
- 1 I feel as if I've had a slight weight loss.
- 2 I have lost 2 pounds or more.
- 3 I have lost 5 pounds or more.

14. Increased Weight (Within the Last Two Weeks):

- 0 I have not had a change in my weight.
- 1 I feel as if I've had a slight weight gain.
- 2 I have gained 2 pounds or more.
- 3 I have gained 5 pounds or more.

15. Concentration/Decision Making:

- 0 There is no change in my usual capacity to concentrate or make decisions.
- 1 I occasionally feel indecisive or find that my attention wanders.
- 2 Most of the time, I struggle to focus my attention or to make decisions.
- 3 I cannot concentrate well enough to read or cannot make even minor decisions.

16. View of Myself:

- 0 I see myself as equally worthwhile and deserving as other people.
- 1 I am more self-blaming than usual.
- 2 I largely believe that I cause problems for others.
- 3 I think almost constantly about major and minor defects in myself.

17. View of My Future:

- 0 I have an optimistic view of my future.
- 1 I am occasionally pessimistic about my future, but for the most part I believe things will get better.
- 2 I'm pretty certain that my immediate future (1-2 months) does not hold much promise of good things for me.
- 3 I see no hope of anything good happening to me anytime in the future.

18. Thoughts of Death or Suicide:

- 0 I do not think of suicide or death.
- 1 I feel that life is empty or wonder if it's worth living.
- 2 I think of suicide or death several times a week for several minutes.
- 3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

19. General Interest:

- 0 There is no change from usual in how interested I am in other people or activities.
- 1 I notice that I am less interested in people or activities.
- 2 I find I have interest in only one or two of my formerly pursued activities.
- 3 I have virtually no interest in formerly pursued activities.

20. Energy Level:

- 0 There is no change in my usual level of energy.
- 1 I get tired more easily than usual.
- 2 I have to make a big effort to start or finish my usual daily activities (for example, shopping, homework, cooking or going to work).
- 3 I really cannot carry out most of my usual daily activities because I just don't have the energy.

21. Capacity for Pleasure or Enjoyment (excluding sex):

- 0 I enjoy pleasurable activities just as much as usual.
- 1 I do not feel my usual sense of enjoyment from pleasurable activities.
- 2 I rarely get a feeling of pleasure from any activity.
- 3 I am unable to get any pleasure or enjoyment from anything.

22. Interest in Sex (Please Rate Interest, not Activity):
- 0 I'm just as interested in sex as usual.
 - 1 My interest in sex is somewhat less than usual or I do not get the same pleasure from sex as I used to.
 - 2 I have little desire for or rarely derive pleasure from sex.
 - 3 I have absolutely no interest in or derive no pleasure from sex.
23. Feeling slowed down:
- 0 I think, speak, and move at my usual rate of speed.
 - 1 I find that my thinking is slowed down or my voice sounds dull or flat.
 - 2 It takes me several seconds to respond to most questions and I'm sure my thinking is slowed.
 - 3 I am often unable to respond to questions without extreme effort.
24. Feeling restless:
- 0 I do not feel restless.
 - 1 I'm often fidgety, wring my hands, or need to shift how I am sitting.
 - 2 I have impulses to move about and am quite restless.
 - 3 At times, I am unable to stay seated and need to pace around.
25. Aches and pains:
- 0 I don't have any feeling of heaviness in my arms or legs and don't have any aches or pains.
 - 1 Sometimes I get headaches or pains in my stomach, back or joints but these pains are only sometime present and they don't stop me from doing what I need to do.
 - 2 I have these sorts of pains most of the time.
 - 3 These pains are so bad they force me to stop what I am doing.
26. Other bodily symptoms:
- 0 I don't have any of these symptoms: heart pounding fast, blurred vision, sweating, hot and cold flashes, chest pain, heart turning over in my chest, ringing in my ears, or shaking.
 - 1 I have some of these symptoms but they are mild and are present only sometimes.
 - 2 I have several of these symptoms and they bother me quite a bit.
 - 3 I have several of these symptoms and when they occur I have to stop doing whatever I am doing.
27. Panic/Phobic symptoms:
- 0 I have no spells of panic or specific fears (phobia) (such as animals or heights).
 - 1 I have mild panic episodes or fears that do not usually change my behavior or stop me from functioning.
 - 2 I have significant panic episodes or fears that force me to change my behavior but do not stop me from functioning.
 - 3 I have panic episodes at least once a week or severe fears that stop me from carrying on my daily activities.
28. Constipation/diarrhea:
- 0 There is no change in my usual bowel habits.
 - 1 I have intermittent constipation or diarrhea which is mild.
 - 2 I have diarrhea or constipation most of the time but it does not interfere with my day-to-day functioning.
 - 3 I have constipation or diarrhea for which I take medicine or which interferes with my day-to-day activities.
29. Interpersonal Sensitivity:
- 0 I have not felt easily rejected, slighted, criticized or hurt by others at all.
 - 1 I have occasionally felt rejected, slighted, criticized or hurt by others.
 - 2 I have often felt rejected, slighted, criticized or hurt by others, but these feelings have had only slight effects on my relationships or work.
 - 3 I have often felt rejected, slighted, criticized or hurt by others and these feelings have impaired my relationships and work.
30. Leadon Paralysis/Physical Energy:
- 0 I have not experienced the physical sensation of feeling weighted down and without physical energy.
 - 1 I have occasionally experienced periods of feeling physically weighted down and without physical energy, but without a negative effect on work, school, or activity level.
 - 2 I feel physically weighted down (without physical energy) more than half the time.
 - 3 I feel physically weighted down (without physical energy) most of the time, several hours per day, several days per week.

Range 0-84 Score: _____

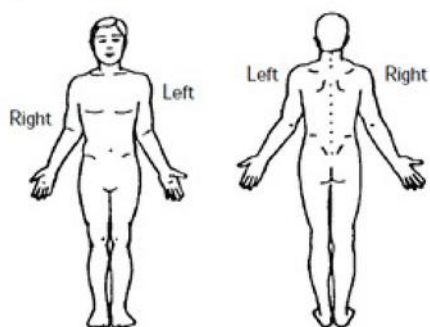
Appendix j: Brief Pain Inventory

Date: ____ / ____ / ____ Time: _____
 Name: _____
Last First Middle initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its **worst** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
 No Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its **least** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
 No Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on **average**.

0 1 2 3 4 5 6 7 8 9 10
 No Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have **right now**.

0 1 2 3 4 5 6 7 8 9 10
 No Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

8) In the past 24 hours, how much **relief** have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0% 10 20 30 40 50 60 70 80 90 100%
 No Complete relief
 relief relief

9) Circle the one number that describes how, during the past 24 hours, pain has **interfered** with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10
 Does not Completely
 interfere interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10
 Does not Completely
 interfere interferes

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10
 Does not Completely
 interfere interferes

D. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10
 Does not Completely
 interfere interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10
 Does not Completely
 interfere interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10
 Does not Completely
 interfere interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
 Does not Completely
 interfere interferes