

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

Pain Disability Questionnaire

Please Fax to

Shade bubbles like this → ●

Print with capital letters within the boxes

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z

PLEASE darken the circle next to **THE ONE CHOICE** which most closely describes your **CURRENT** condition.

1. Does your pain interfere with your normal work inside and outside the home?

Work normally Unable to work at all
0 1 2 3 4 5 6 7 8 9 10
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

Take care of self completely Need help with all personal care
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

3. Does your pain interfere with your traveling?

Travel anywhere I like Only travel to see doctors
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

4. Does your pain affect your ability to sit or stand?

No problems Can not sit/stand at all
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

No problems Can not do at all
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?

No problems Can not do at all
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

7. Does your pain affect your ability to walk or run?

No problems Can not walk/run at all
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

8. Has your income declined since your pain began?

No decline Lost all income
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

9. Do you have to take pain medication every day to control your pain?

No medication needed On pain medication throughout day
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

10. Does your pain force you to see doctors much more often than before your pain began?

Never see doctors See doctors weekly
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?

No problems Never see them
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

12. Does your pain interfere with recreational activities and hobbies that are important to you?

No interference Total interference
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?

Never need help Need help all the time
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

14. Do you now feel more depressed, tense, or anxious than before your pain began?

No depression/tension Severe depression/tension
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?

No problems Severe problems
0 1 2 3 4 5 6 7 8 9 10
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

F Name Initial L Name Initial Last 4 digits of SSN

This questionnaire is designed to enable the doctor to understand how much your neck and/or back pain has affected your ability to manage your everyday activities.

Staff use only

Terry L Wiley		DC		Discharge	
Doctor Name	Doctor ID	Designation	60	90	150

Date

Draft



Examiner Signature

Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Total Score _____

PRINTED

Signature

Date