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 Questionaire

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 your 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 homeand 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 — Doctor Name | Doctor ID | DC — Designation | 60 | 90 | 150 | Discharge ○

Date ___ / ___ / ___

Draft

Examiner Signature

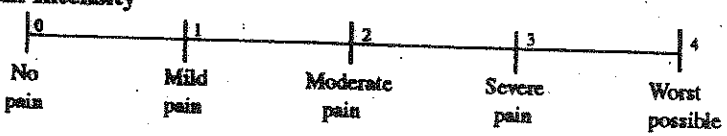
With permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. Spine 2004; 29 (20): 2280-2302.

Functional Rating Index

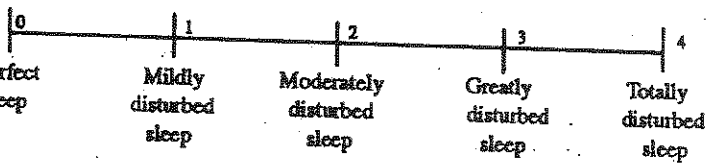
For use with Neck and/or Back Problems only.

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.**

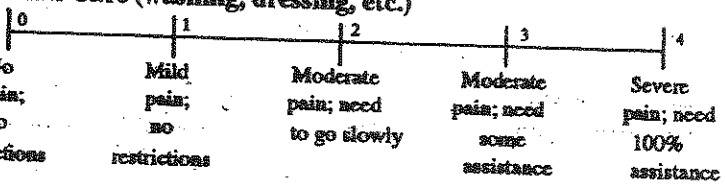
1. Pain Intensity



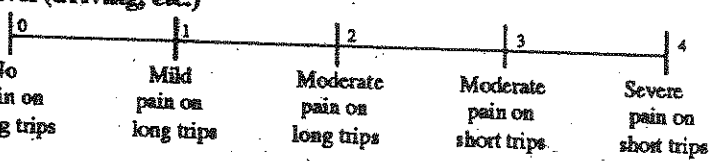
2. Sleeping



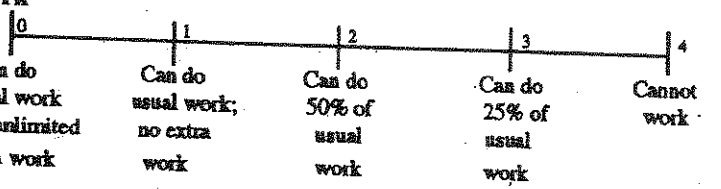
3. Personal Care (washing, dressing, etc.)



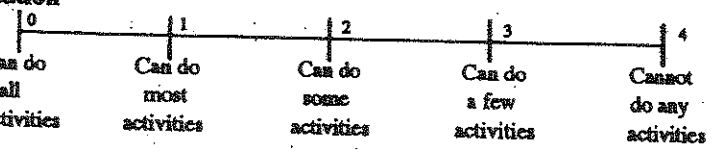
4. Travel (driving, etc.)



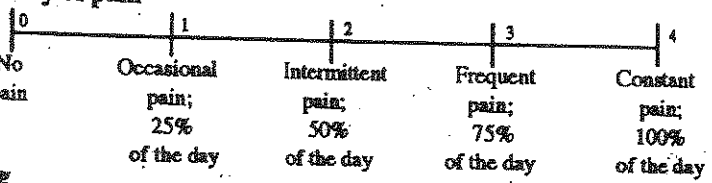
5. Work



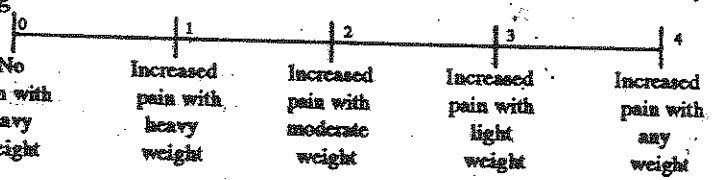
6. Recreation



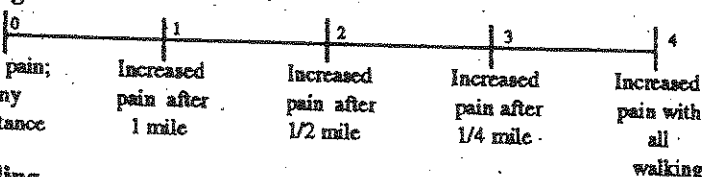
7. Frequency of pain



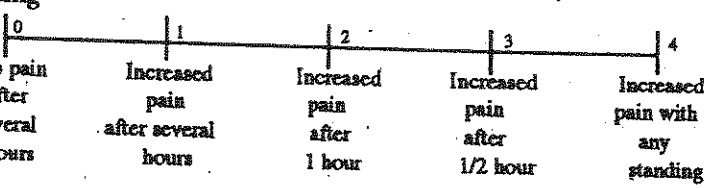
8. Lifting



9. Walking



10. Standing



Total Score _____

Name _____
PRINTED

_____
Signature

_____
Date