

Name: _____

Date: _____

Date of Injury: _____

Please Read: This questionnaire has been designed to give your health care provider information as to how your pain affects your daily activities. Be sure that these are your answers. Do not ask someone else to complete this questionnaire for you. Please mark 'X' along the line that expresses your thoughts from 0-100 in each sections.

Section I: Pain and Intensity

To what degree do you rely on pain medication or pain-relieving substances for you to be comfortable?

None Some All the time
0% _____ : _____ : _____ : _____ : _____ : _____ 100%

Section II: Personal Care

How much does pain interfere with your personal care (getting out of bed, teeth brushing, dressing, etc?)

None Some Can't get out of bed
0% _____ : _____ : _____ : _____ : _____ : _____ 100%

Section III: Lifting

How much limitations do you notice in lifting?

None Some Can't lift anything.
0% _____ : _____ : _____ : _____ : _____ : _____ 100%

Section IV: Walking

Compared to how far you could walk before your injury or back trouble, how much does pain restrict walking?

None Almost same Very little I can't walk
0% _____ : _____ : _____ : _____ : _____ : _____ 100%

Section V: Sitting

Back pain limits my sitting in a chair to:

None Same I can't sit at all
0% _____ : _____ : _____ : _____ : _____ : _____ 100%

Section VI: Standing

How much does pain interfere with your tolerance to stand for long periods?

None(same as before) Some I can't stand
0% _____ : _____ : _____ : _____ : _____ : _____ 100%

Section VII: Sleeping

How much does pain interfere with your sleep?

None(Same as before) Some I can't sleep at all

0% _____:_____:_____:_____:_____ 100%

Section VIII: Social Life

How much does pain interfere with your social life (Dancing, Games, going out, eating with friends, etc.)?

None Some No activities

0% _____:_____:_____:_____:_____ **100%**

Section IX: Traveling

How much does pain interfere with traveling in a car?

None Some I can't travel

0% _____:_____:_____:_____:_____ 100%

Section X: Vocational

How much does pain interfere with your job?

None Some I can't work

0% _____:_____:_____:_____:_____ 100%

Sections XI: Anxiety/Mood

How much control do you feel that you have over demands made on you?

Total(no change) Some None

0% _____:_____:_____:_____:_____ 100%

Section XII: Emotional Control

How much control do you feel you have over your emotions?

Total (no change) Some None

0% _____:_____:_____:_____:_____ **100%**

Section XIII: Depression

How depressed have you been since the onset of pain?

Not depressed _____ **overwhelmed by depression**

0% _____ **100%**

Section XIV: Interpersonal Relationships

How much do you think has changed your relationship with others?

No changes _____ Drastically changed

0% _____ 100%

Section XV: Social Support

How much support do you need from others to help you during this onset of pain (taking over chores, meals, etc.)?

None needed _____ All the time

0% _____ 100%

Section XVI: Punishing Response

How much do you think others express irritation, frustration, or anger towards you because of your pain?

None _____ Some _____ All the time

0% _____ 100%