

Pain Disability Questionnaire

Name: _____

Date: _____

Please read:

This survey asks for your view about how your pain affects how you function in everyday activities. This information will help you and your health team know how you feel and how well you are able to do your daily tasks at this time.

Please answer every question by marking an "X" along the line to show how much your pain problem has affected you (from having no problems at all to having the most severe problems you can imagine).

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

Work Normally Unable to work at all

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

Take care of myself completely Need help with all my personal care

3. Does your pain interfere with your traveling?

Travel anywhere I like Only travel to see health care providers

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

No problems Cannot do at all

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

No problems Cannot do at all

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

No problems Cannot do at all

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

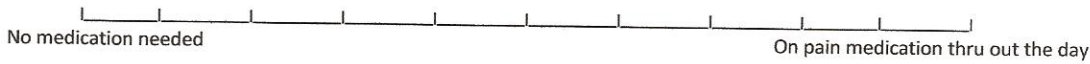
No problems Cannot do at all

COMPLETE OTHER SIDE----->

8. Has your income declined since your pain began?



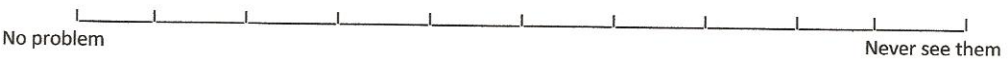
9. Do you have to take pain medication every day to control your pain?



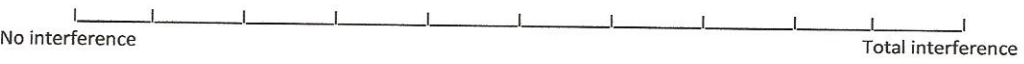
10. Does your pain force you to see doctors much more often than before your pain began?



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



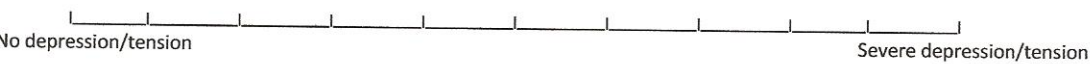
12. Does your pain interfere with recreational activities and hobbies that are important to you?



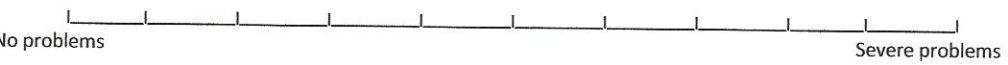
13. Do you need help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?



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



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



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Functional(90): 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 12 ___ 13 ___ = ___

Psychosocial(60): 8 ___ 9 ___ 10 ___ 11 ___ 14 ___ 15 ___ = ___

Total(150) = ___