NAME:
DATE OF ACCIDENT:
TODAY'S DATE:

PAIN DISABILITY QUESTIONNAIRE

This survey asks for your views about how your pain ***now*** affects your function in everyday activities. This information will help you and your doctor 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, and etc.?**

Take care of myself completely — Need help w/all my 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 — Cannot sit/stand at all

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

No problems — Cannot do at all

6. **Does your pain affect your ability 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 run/walk 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 the day

10. Does your pain force you to see doctors much more often than the 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 problem — 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 inside and outside the home because of your pain?

Never need help — Need help all the time

14. Do you 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, or work activities?

No Problems — Severe problems

_____ _____

SIGNATURE **DATE**