



FUNCTIONAL QUESTIONNAIRE

Patient's Name: _____ Date: _____

How long have you been in pain? Years: _____ Months: _____ Weeks: _____

You may be asked to complete this form on subsequent visits during your treatment. Please do not complete this form if your medical problem does not involve pain or disability.

PLEASE READ PRIOR TO COMPLETING THIS QUESTIONNAIRE

This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section only the one box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please mark only the box which most closely describes your problem.

Section 1: Pain Intensity

- I can tolerate the pain I have without having to use pain killers
The pain is bad but I manage without taking pain killers.
Pain killers give complete relief from pain.
Pain killers give moderate relief from pain.
Pain killers give very little relief from pain.
Pain killers have no effect on the pain and I do not use them.

Section 2: Personal Care

- I can look after myself normally without causing extra pain.
I can look after myself normally but it causes extra pain.
It is painful to look after myself and I am slow and careful.
I need some help but manage most of my personal care
I need help every day in most aspects of self care.
I do not get dressed, wash with difficulty and stay in bed.

Section 3: Lifting

- I can lift heavy weights without extra pain.
I can lift heavy weights but I gives extra pain.
Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (e.g. on the table)
Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
I can lift only very light weights.
I cannot lift or carry anything at all.

Section 4: Walking

- Pain does not prevent me walking any distance.
Pain prevents me walking more than 1 mile.
Pain prevents me walking more that 112 mile.
Pain prevents me walking more than 114 mile.

Section 5: Sitting

- I can sit in any chair as long as I like.
I can only sit in my favorite chair as long as I like.
Pain prevents me from sitting for more than 1 hour.
Pain prevents me from sitting for more than 30 min.
Pain prevents me from sitting for more than 10 min.
Pain prevents me from sitting at all.

Section 6: Standing

- I can stand as long as I want without extra pain.
I can stand as long as I want with a little pain.
Pain prevents me from standing for more than an hour
Pain prevents me from standing for more than 30 min.
Pain prevents me from standing for more than 10 min.
Pain prevents me from standing at all.

Section 7: Sleeping

- Pain does not prevent me from sleeping well.
I can sleep well only by using tablets.
Even when I take tablets I have less than six hours of sleep.
Even when I take tablets I have less than four hours of sleep.
Even when I take tablets I have less than 2 hours of sleep.
Pain prevents me from sleeping at all.

Section 8: Sex Life

- My sex life is normal and causes no pain.
My sex life is normal but increased on the degree of pain.
My sex life in nearly normal but is very painful.
My sex life is nearly absent because of pain.
Pain prevents me from having any sex life at all.

Section 9: Social Life

- My social life is normal and gives me no extra pain.
My social life is normal but increases the degree of pain.
Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, sports, etc.
Pain has restricted my social life and I do not go out as often.
Pain has restricted my social life to my home.
I have no social life because of pain.

Section 10: Traveling

- I can travel anywhere without extra pain.
I can travel anywhere but it gives me extra pain.
Pain is bad but I manage journeys over two hours.
Pain restricts me to journeys of less than one hour.
Pain restricts me to short necessary journeys under 30 min.
Pain prevents me from traveling except to the doctor or hospital.

Comments:

PAIN LOCATIONS

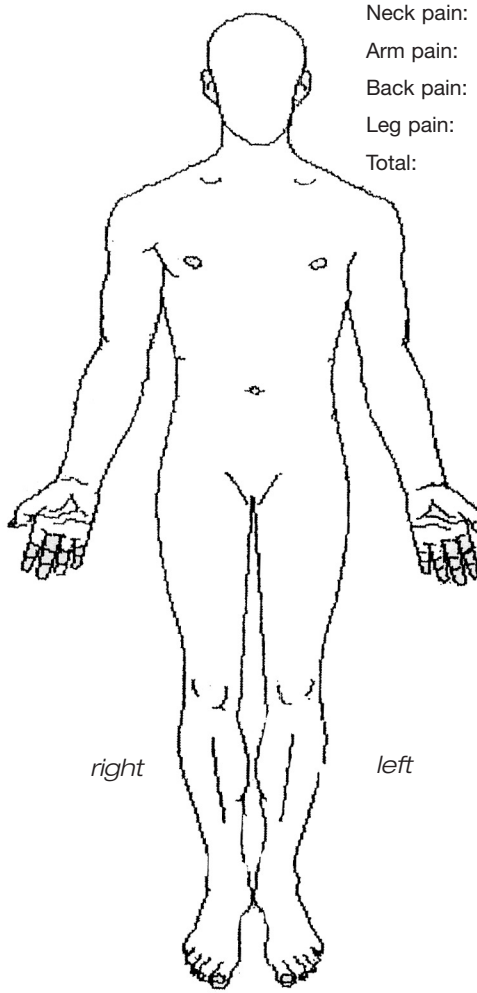
Patient's Name: _____ Date: _____

Age: _____

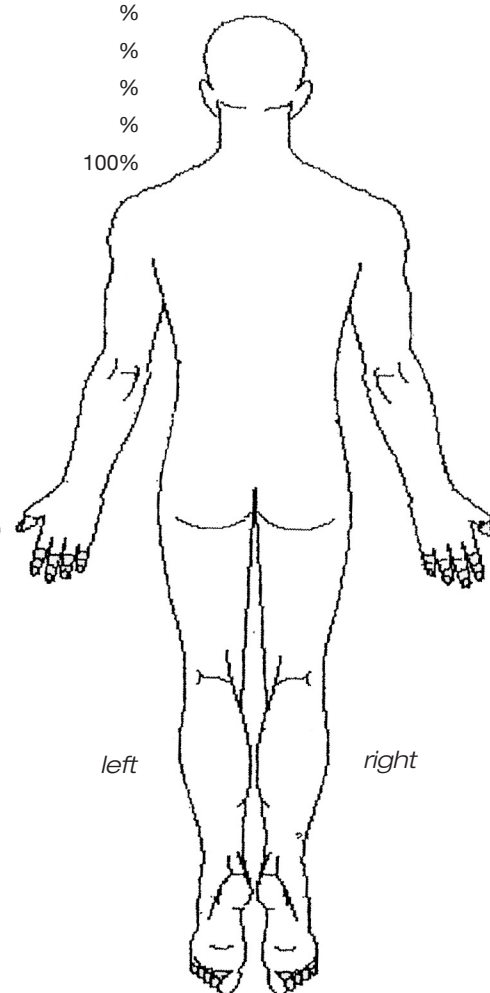
Where is your pain now? Please mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation using the symbols indicated below. Include all affected areas. Just to complete the picture, please draw in your face.

active pain	^^^^ ^^^^	numb	0000 0000	pins & needles	◆◆◆◆ ◆◆◆◆	burning	XXXXX XXXXX	radiating pain	////// //////
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	Neck pain:		%
			%
			%
			%
			100%



right left



left right

How bad is your pain now? (1=no pain 10=worst pain)

1 2 3 4 5 6 7 8 9 10

How consistent is your pain now?

Continuous

Positional

Intermittent (on/off)

Unable to rate



TREATMENT INTENSITY SCORE

Patient's Name: _____ Date: _____

Date of Birth: _____

Please answer the questions below, choosing the answer that most closely describes your situation at the present time. We understand there may be one or more alternatives that may apply to you. Please choose the one you feel is most descriptive of your problem.

1. What medications are you taking for your pain?
 - a. None
 - b. Tylenol, Aspirin, Motrin, Aleve or other non-prescription pain medication
 - c. Vicodin, Coedine, Darvocet, Ultram
 - d. Medrol Dose Pack Morphine Analogs (oxycontin, MS Contin, Percocet, etc.)

2. How long is the pain relieved before you need medication again?
 - a. 24 hours or more (rarely take them)
 - b. 12 hours
 - c. 8 hours
 - d. 6 hours
 - e. 4 hours
 - f. Less than 4 hours

3. How long have you taken these medications?
 - a. Use them occasionally only (i.e. do not need them every day)
 - b. 6 weeks
 - c. 3 months
 - d. 6 months
 - e. 1 year
 - f. 2 years or more

4. Have you needed to seek other treatment options, specifically because of the pain in your neck, shoulder, arms, buttocks, legs or back?
 - a. None
 - b. Massage therapy, Shiatsu, Acupressure, etc.
 - c. Supervised Physiotherapy and/or Chiropractor
 - d. Acupuncture, Acupressure, Alternative Medicine Therapies
 - e. Injections such as Nerve Root Blocks or Epidural Steroids
 - f. Spinal Cord Stimulator, Morphine Pump

5. How often have you had to see a Doctor, Therapist, or gone to the Emergency Room, specifically because of unbearable pain (please don't include/disregard any routine follow-up visit)?
 - a. Never
 - b. Once in 6 months or less
 - c. Once in 3 months
 - d. Every 6 weeks
 - e. Every week or 2-3 times a week
 - f. Needed admission to the hospital for severe pain