# Pain Disability Questionnaire

This survey asks for your views about how your pain now affects how you 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).

**BE SURE TO ANSWER ALL QUESTIONS**

**1. Does your pain interfere with your normal work inside and outside the home?**
I_____2_____3_____4_____5_____6_____7_____8_____9_____I0
*Work normally* *Unable to work at all*

**2. Does your pain interfere with personal care (such as washing, dressing, etc.)?**
I_____2_____3_____4_____5_____6_____7_____8_____9_____I0
*Take care of myself completely* *Need help with all of my personal care*

**3. Does your pain interfere with your traveling?**
I_____2_____3_____4_____5_____6_____7_____8_____9_____I0
*Travel anywhere I like* *Only travel to see Doctors*

**4. Does your pain affect your ability to sit or stand?**
I_____2_____3_____4_____5_____6_____7_____8_____9_____I0
*No problems* *Cannot sit/ stand at all*

**5. Does your pain affect your ability to lift overhead, grasp objects or reach for things?**
I_____2_____3_____4_____5_____6_____7_____8_____9_____I0
*No problems* *Cannot do at all*

**6. Does your pain affect your ability to lift objects off the floor, bend, stoop or squat?**
I_____2_____3_____4_____5_____6_____7_____8_____9_____I0
*No problems* *Cannot do at all*

**7. Does your pain affect your ability to walk or run?**
I_____2_____3_____4_____5_____6_____7_____8_____9_____I0
*No problems* *Cannot walk/ run at all*

**8. Has your income declined since your pain began?**
I_____2_____3_____4_____5_____6_____7_____8_____9_____I0
*No decline* *Lost all income*

**9. Do you have to take pain medication every day to control your pain?**
I_____2_____3_____4_____5_____6_____7_____8_____9_____I0
*No medication needed* *On pain medication throughout the day*

**10. Does your pain force you to see Doctors much more often than before your pain began?**
I_____2_____3_____4_____5_____6_____7_____8_____9_____I0
*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?**
I_____2_____3_____4_____5_____6_____7_____8_____9_____I0
*No problem* *Never see them*

**12. Does your pain interfere with the recreational activities and hobbies that are important to you?**
I_____2_____3_____4_____5_____6_____7_____8_____9_____I0
*Normal activity* *No recreation /hobbies at all*

**13. Do you need the help of your Family and Friends to complete everyday tasks because of your pain?**
I_____2_____3_____4_____5_____6_____7_____8_____9_____I0
*Never need help* *Need help all the time*

**14. Do you feel more depressed stressed or anxious than before your pain began?**
I_____2_____3_____4_____5_____6_____7_____8_____9_____I0
*No depression/ tension* *Severe depression/ tension*

**15. Are there emotional problems caused by your pain that interfere with your family, social or work activities?**
I_____2_____3_____4_____5_____6_____7_____8_____9_____I0
*No problems* *Severe problems*

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