PAIN QUESTIONNAIRE

	Scale:	**0 =**	**Not at all**								
		1-3 =	**Slightly**								
		4-6 =	**Moderately**								
		7-10 =	**Severe or Greatly**								
			1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
	How Severe is your pain…										
1	Right Now										
2	At its Worst										
3	On Average										
	How Much Does Your Pain Interfere With Your Ability To…										
4	Walk One Block										
5	Carry Grocery Bags										
6	Sit For 1/2 Hour										
7	Stand For 1/2 Hour										
8	Sleep										
9	Participate In Social Activities										
10	Travel 1 Hour By Car										
11	Get a Milk Jug										
12	Shower/Bathe/Dress/Groom										
13	Do Housework										
14	Write or Type										
15	Lift a Heavy Box										
16	Engage In Sexual Activities										
17	Concentrate										
18	Maintain Your Relationships With Family/Friends										
19	Reach Overehead										
20	Open Jars										
	Due To Your Pain, During The Past Week…										
21	How Depressed Have You Been										
22	How Irritable Have You Been										
23	How Worried Have You Been										
	What Would You Like To Do More Of, Or Enjoy More...										
24	Hobbies										
25	Sports										
26	Exercise										
27	Gardening										
28	Playing With Children										
29	Sewing/Knitting										
30	Other										

Name: _____ Date: _____ Account Number: _____