PAIN DISABILITY QUESTIONAIRE

Patient Name: _____ Date: _____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and select ONE number on EACH scale that best describes how you feel.

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

0 = you work normally 10 = you are unable to work at all

0

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

0 = you take care or yourself completely 10 = you need help with all personal care

0

3. Does your pain interfere with your traveling?

0 = you travel anywhere 10 = you only travel to see doctors

0

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

0 = no problems 10 = you cannot sit or stand at all

10

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

0 = no problems 10 = you cannot do it at all

10

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

0 = no problems 10 = you cannot do it at all

10

7. Does your pain affect your ability to walk?

0 = no problems 10 = you cannot run or walk

10

8. Has your income declined since your pain began?

0 = no decline 10 = you lost all income

10

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

0 = no medication needed 10 = you are on medication throughout the day

10

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

0 = you never see doctors 10 = you see doctors every week

10

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

0 = no interference 10 = you never see them

10

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

0 = no interference 10 = total interference

10

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

0 = you never need help 10 = you need help all the time

10

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

0 = no depression or tension 10 = severe depression or tension

10

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

0 = no problems 10 = severe problems

10