

Southwest Ohio Pain Management/Desert Valley Physicians  
Pain Disability Questionnaire

Please Fax to (513) 229-7888

Patient Signature \_\_\_\_\_

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

Shade bubbles like this → ●

PLEASE darken the circle next to THE ONE CHOICE which most closely describes your *CURRENT* condition.

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

Work normally	Unable to work at all
0—1—2—3—4—5—6—7—8—9—10	
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○	
  
2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
 

Take care of self completely	Need help with all personal care
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○	
  
3. Does your pain interfere with your traveling?
 

Travel anywhere I want	Only travel to see doctors
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○	
  
4. Does your pain affect your ability to sit or stand?
 

No problems	Can not sit/stand at all
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○	
  
5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
 

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

No problems	Can not do at all
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○	
  
7. Does your pain affect your ability to walk or run?
 

No problems	Can not walk/run 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 day
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○	
  
10. Does your pain force you to see doctors much more often than before your 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 problems	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 outside the home and housework) because of your pain?
 

Never need help	Need help all the time
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○	
  
14. Do you now 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, and/or work activities?
 

No problems	Severe problems
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○	
0---1---2---3---4---5---6---7---8---9---10	

Patient ID \_\_\_\_\_

Date \_\_\_\_\_

○ Cervical   ○ Thoracic   ○ Lumbar   ○ Joint   ○ Fibromyalgia   ○ Headache   ○ Other