Patient Name: _____Date: _____

QUADRUPLE VISUAL ANALOGUE SCALE

Please circle the number that best describes the question being asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example: *Headache* *Neck* *Low Back*

0 1 ② 3 4 ⑤ 6 7 ⑧ 9 10

No Pain *Worst Possible Pain*

What is your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

No Pain *Worst Possible Pain*

What is your TYPICAL or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

No Pain *Worst Possible Pain*

What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

0 1 2 3 4 5 6 7 8 9 10

No Pain *Worst Possible Pain*

What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

0 1 2 3 4 5 6 7 8 9 10

No Pain *Worst Possible Pain*

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst. **Please circle the number which best describes how your typical level of pain affects these six categories of activities.**

1. **FAMILY/ AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL:

   0 1 2 3 4 5 6 7 8 9 10

   COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION
2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES:

   0 1 2 3 4 5 6 7 8 9 10

   COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION
3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING-OUT AND ATTENDING OTHER SOCIAL FUNCTIONS:

   0 1 2 3 4 5 6 7 8 9 10

   COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION
4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS:

   0 1 2 3 4 5 6 7 8 9 10

   COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION
5. **SELF-CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED:

   0 1 2 3 4 5 6 7 8 9 10

   COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION
6. **LIFE-SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING:

   0 1 2 3 4 5 6 7 8 9 10

   COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

SCORE ____ [60]

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Dr's. Signature _____Date:_____