Murfreesboro Family Chiropractic Rehabilitation, PLLC.

Pain Index Questionnaire

Please Print

Patient Name _____ **D.O.B.** _____ **Date** _____

Pain Index

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/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 social functions with friends -

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

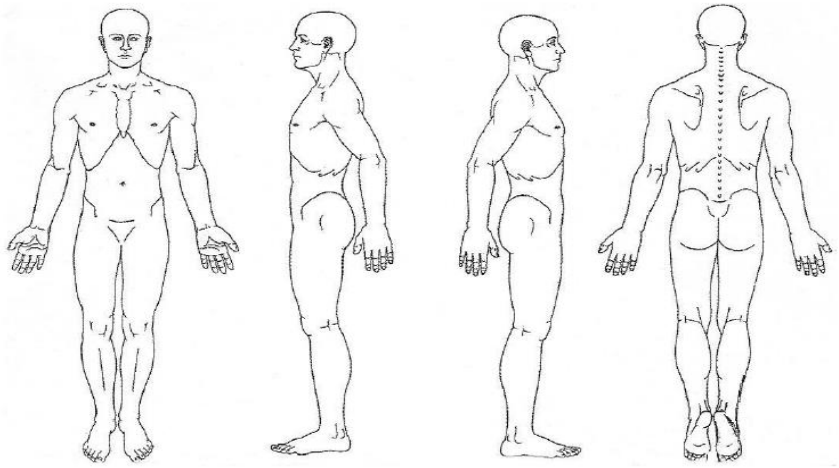
completely able to function — totally unable to function

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] Benchmark -5 = _____



Please mark the areas on the picture below that correspond to the areas of your body where you feel the described sensations. Use appropriate symbols. Mark areas of radiation. Include all affected areas.

Do Not Simply Circle The Affected Area

Numbness **----** Aching ********

Pins & Needles **oooo**

Burning **xxxx** Stabbing **////**

Signed _____ **Date** ____/____/____