Health First Chiropractic Clinic, P.C.
"Caring for Your Health First"

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Pain Disability Questionnaire

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 circle the ONE number on EACH scale that best describes now you feel.

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 myself completely — Need help with my personal care
0 1 2 3 4 5 6 7 8 9 10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0 1 2 3 4 5 6 7 8 9 10

4. Does your pain affect your ability to sit or stand?
No problems — Cannot sit/stand at all
0 1 2 3 4 5 6 7 8 9 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — Cannot do at all
0 1 2 3 4 5 6 7 8 9 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — Cannot do at all
0 1 2 3 4 5 6 7 8 9 10

7. Does your pain affect your ability to run or walk?
No problems — Cannot walk or run at all
0 1 2 3 4 5 6 7 8 9 10

8. Has your income declined since your pain began?
No decline — Lost all income
0 1 2 3 4 5 6 7 8 9 10

9. Do you have to take pain medication every day to control your pain?
No medication needed — On pain medication throughout the day
0 1 2 3 4 5 6 7 8 9 10

10. Does your pain force you to see doctors more often than before your pain began?
Never see doctors — See doctors weekly
0 1 2 3 4 5 6 7 8 9 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem — Never see them
0 1 2 3 4 5 6 7 8 9 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — Total interference
0 1 2 3 4 5 6 7 8 9 10

13. Do you need the help of family and friends to complete everyday tasks because of your pain?
Never need help — Need help all the time
0 1 2 3 4 5 6 7 8 9 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — Severe depression/tension
0 1 2 3 4 5 6 7 8 9 10

15. Are there emotional problems caused by your pain that interfere with your family, social, or work activities?
No problems — Severe problems
0 1 2 3 4 5 6 7 8 9 10

Patient Signature: ______________________________ Date: ____________

Provider Signature: ______________________________

Implemented 6/20/2016

With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 1004: 29 (20): 2290-2302.