

Comprehensive Pain Management Institute

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By accurately answering the questions below, you will help us to better understand how your life is impacted by your pain. We need to know to what degree the pain is detracting from the life you had previously. Please indicate overall function, rather than times when pain is at its worst. Please mark [X] along the line at a location which indicates the degree of impact on your life.

Current level of pain

{None} 0 (-----|-----|-----|-----|-----|-----|-----|-----|-----) 10 {Worst}

Pain at its best

{None} 0 (-----|-----|-----|-----|-----|-----|-----|-----|-----) 10 {Worst}

Pain at its worst

{None} 0 (-----|-----|-----|-----|-----|-----|-----|-----|-----) 10 {Worst}

Family and Home Responsibilities [Activities necessary to maintain households – yard work, errands, favors for family members (transporting children etc)]

{Normal} 0 (-----|-----|-----|-----|-----|-----|-----|-----|-----) 10 {Totally Disabled}

Recreation [Hobbies, sports, and other leisure activities]

{Normal} 0 (-----|-----|-----|-----|-----|-----|-----|-----|-----) 10 {Totally Disabled}

Social Activities [Activities which involve participation with friends and non-family acquaintances – eg parties, dining out, theater, movies, events, and other social functions]

{Normal} 0 (-----|-----|-----|-----|-----|-----|-----|-----|-----) 10 {Totally Disabled}

Occupation [Activities that are directly or indirectly related to one's job – both for pay and unpaid, such as housework and volunteering]

{Normal} 0 (-----|-----|-----|-----|-----|-----|-----|-----|-----) 10 {Totally Disabled}

Sexual Behavior [Departure from normal frequency and quality of one's sex life]

{Normal} 0 (-----|-----|-----|-----|-----|-----|-----|-----|-----) 10 {Totally Disabled}

Self-care [Activities which involve personal maintenance and independent daily living – self-care, dressing, driving]

{Normal} 0 (-----|-----|-----|-----|-----|-----|-----|-----|-----) 10 {Totally Disabled}

Life-support [Basic activities that support your life – breathing, eating, sleeping, etc]

{Normal} 0 (-----|-----|-----|-----|-----|-----|-----|-----|-----) 10 {Totally Disabled}

Sleep [How well are you sleeping currently]

{Best} 0 (-----|-----|-----|-----|-----|-----|-----|-----|-----) 10 {Complete Insomnia}

Pain Impact Questionnaire (v.1.0)

Date: _____

Patient Name: _____