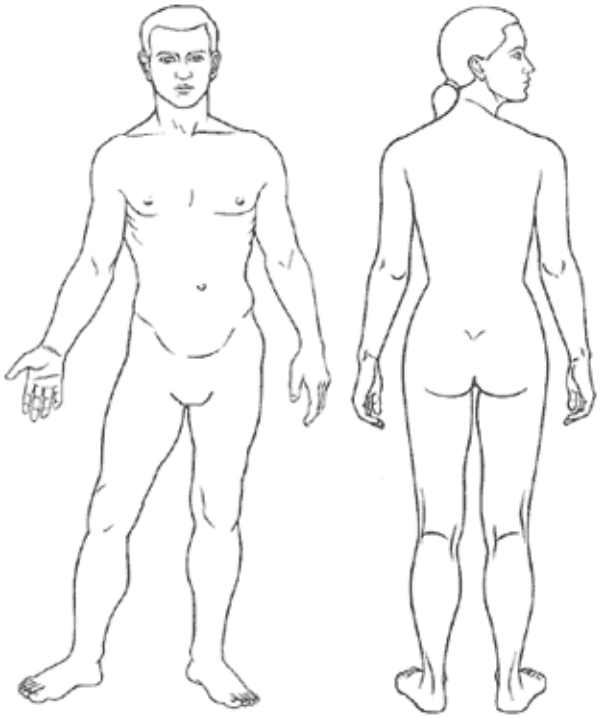
acupuncture center

General Pain Index Questionnaire

Name: _____ Date: _____

Please mark areas of pain on diagrams.



Did the pain start from trauma? Y or N

Is the pain:
Sharp, Cramping, Fixed, Burning, Dull, Aching, Moving, Other
_____

Does the following lessen the pain?
Pressure, Exercise, Cold, Heat, Rest, Other
_____

Does the following worsen the pain?
Pressure, Cold, Heat, Damp weather, other
_____

Pain/Discomfort of main complaint:
Least 1 2 3 4 5 6 7 8 9 10 Worst

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.

Family/at-home responsibilities such as yard work, chores around the house
Able to function 0 1 2 3 4 5 6 7 8 9 10 Unable to function

Recreation including hobbies, sports or other leisure activities
Able to function 0 1 2 3 4 5 6 7 8 9 10 Unable to function

Social activities including parties, theater, concerts, dining-out and attending other social functions
Able to function 0 1 2 3 4 5 6 7 8 9 10 Unable to function

Employment including volunteer work and homemaking tasks
Able to function 0 1 2 3 4 5 6 7 8 9 10 Unable to function

Self-care such as taking a shower, driving or getting dressed
Able to function 0 1 2 3 4 5 6 7 8 9 10 Unable to function

Life-support activities such as eating and sleeping
Able to function 0 1 2 3 4 5 6 7 8 9 10 Unable to function

SCORE _____ (60) Benchmark = 5 _____

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