Functional Impairment Pain Scale

_____
Date of Assessment

Patient Name _____ Doctor _____

1. Please list the area(s) where you are experiencing pain. (e.g. back, neck) _____

_____

_____

2. How long have you been experiencing pain? ☐ < 30 days ☐ 1-6 months ☐ > 6 months

3. Is the pain constant? ☐ Yes ☐ No

4. How frequently do you experience this pain?
   ☐ Daily (throughout the day/night) ☐ Periodically (associated with an activity)
   ☐ Periodically (associated with a condition such as arthritis)

5. Has the pain changed since you first experienced it? ☐ Yes ☐ No
   If yes please describe:
   ☐ Expanded or moved to another location ☐ Pain was stable but now radiates ☐ Other _____
   ☐ Pain more severe ☐ Pain less severe

6. How severe is the pain?	**Level of Pain** 0 1 2 3 4 5 6 7 8 9 10	No Pain … Worst Pain Imaginable
7. How much does the pain limit your normal daily activities?	**General Activity** 0 1 2 3 4 5 6 7 8 9 10	No Impact … Cannot Conduct Normal Daily Activities
8. To what extent is the pain hindering your sleep?	**Ability to Sleep** 0 1 2 3 4 5 6 7 8 9 10	No Impact … Cannot Sleep
9. Do you feel irritable, angry or depressed due to the pain?	**Mood** 0 1 2 3 4 5 6 7 8 9 10	No Impact … Severe Impact
10. Has the pain interfered with your appetite?	**Appetite** 0 1 2 3 4 5 6 7 8 9 10	Normal … No Appetite
11. Are you able to attend work/school in your normal routine?	**Absences** 0 1 2 3 4 5 6 7 8 9 10	Normal … Absent from Activities
12. Has your pain inhibited your ability for self-care (e.g. sitting down, bathing, etc)?	**Self Care** 0 1 2 3 4 5 6 7 8 9 10	Normal … Cannot Function Independently

13. Are you currently taking any medication for pain management? ☐ Yes ☐ No

14. Do you generally use over-the-counter medications that may contain acetaminophen (e.g. Tylenol®)? ☐ Yes ☐ No

15. Please list all current medications: _____

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