

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)

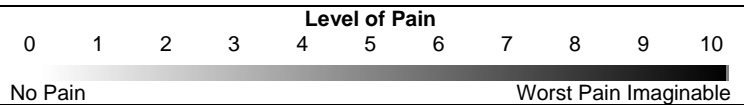
5. Has the pain changed since you first experienced it? Yes No

If yes please describe:

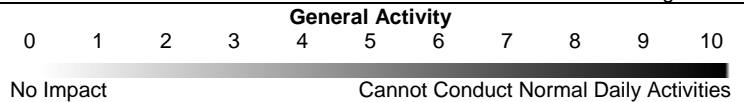
Expanded or moved to another location Pain was stable but now radiates Other _____

Pain more severe Pain less severe

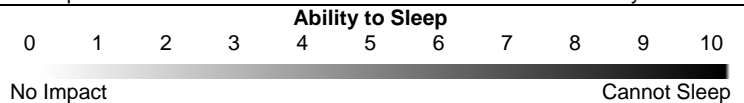
6. How severe is the pain?



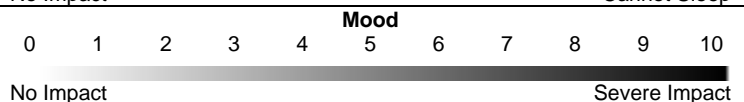
7. How much does the pain limit your normal daily activities?



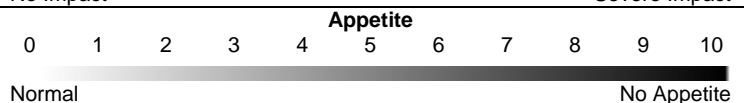
8. To what extent is the pain hindering your sleep?



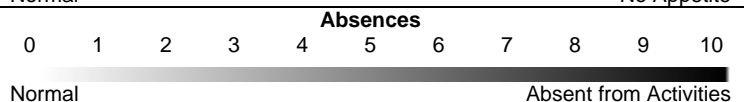
9. Do you feel irritable, angry or depressed due to the pain?



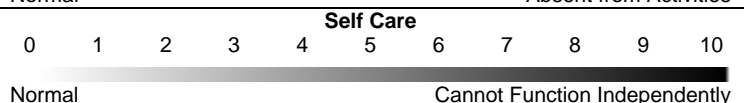
10. Has the pain interfered with your appetite?



11. Are you able to attend work/school in your normal routine?



12. Has your pain inhibited your ability for self-care (e.g. sitting down, bathing, etc)?



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: _____

