PAIN OUTCOMES QUESTIONNAIRE (Short form)

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We ask that all patients regardless of condition complete the remainder of the questionnaire.

I. INSTRUCTIONS:

Please circle the number that best describes the question being asked.

Choose only 1 number per question.

1) Enter today’s date: _____/_____/________ (dd/mm/yyyy)

2) On a scale of 0 to 10, with 0 being no pain at all and 10 being the worst possible pain, how would you rate your pain on average during the past week?

   ← No Pain 0 1 2 3 4 5 6 7 8 9 10 → Worst Possible Pain

3) Does your pain interfere with your ability to walk?

   ← Not at all 0 1 2 3 4 5 6 7 8 9 10 → All the time

4) Does your pain interfere with your ability to carry/handle everyday objects such as a bag of groceries or books?

   ← Not at all 0 1 2 3 4 5 6 7 8 9 10 → All the time

5) Does your pain interfere with your ability to climb stairs?

   ← Not at all 0 1 2 3 4 5 6 7 8 9 10 → All the time

6) Does your pain require you to use a cane, walker, wheelchair, or other devices?

   ← Not at all 0 1 2 3 4 5 6 7 8 9 10 → All the time

7) Does your pain interfere with your ability to bathe yourself?

   ← Not at all 0 1 2 3 4 5 6 7 8 9 10 → All the time

8) Does your pain interfere with your ability to dress yourself?

   ← Not at all 0 1 2 3 4 5 6 7 8 9 10 → All the time

9) Does your pain interfere with your ability to use the bathroom?

   ← →
10) Does your pain interfere with your ability to manage your personal grooming (for example, combing your hair, brushing your teeth, etc.)?

11) Does your pain affect your self-esteem or self-worth?

12) How would you rate your physical activity?

13) How would you rate your overall energy?

14) How would you rate your strength and endurance today?

15) How would you rate your feelings of depression today?

16) How would you rate your feelings of anxiety today?

17) How much do you worry about re-injuring yourself if you are more active?

18) How safe do you think it is for you to exercise?

19) Do you have problems concentrating on things today?
20) How often do you feel tense?

Not at all  0  1  2  3  4  5  6  7  8  9  10  All the time