General Pain Index Questionnaire

We would like to know how much your pain **presently** prevents you for 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.

*Please **circle the number** which best describes how your typical level of pain affects these six categories of activities.*

1. Family / At-home responsibilities such as yard work, chores around the house or driving the kids to school –

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

2. Recreation including hobbies, sports or other leisure activities –

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

3. Social activities including parties, theater, concerts, dining-out and attending other social functions –

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

4. Employment inducing volunteer work and homemaking tasks –

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

5. Self-Care such as taking a shower, driving or getting dressed –

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

6. Life-Support activities such as eating and sleeping –

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

Patient Name: _____ **Date: _____**

Score: _____ (60)

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: _____ Date: _____

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

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

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1 – What is your pain RIGHT NOW?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

_____ _____

Patient's Signature Examiner's Signature

HEADACHE DISABILITY INDEX

Patient Name _____ Date _____

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
2. My headache is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO		
____	____	____	E1.	Because of my headaches I feel handicapped.
____	____	____	F2.	Because of my headaches I feel restricted in performing my routine daily activities.
____	____	____	E3.	No one understands the effect my headaches have on my life.
____	____	____	F4.	I restrict my recreational activities (eg, sports, hobbies) because of my headaches.
____	____	____	E5.	My headaches make me angry.
____	____	____	E6.	Sometimes I feel that I am going to lose control because of my headaches.
____	____	____	F7.	Because of my headaches I am less likely to socialize.
____	____	____	E8.	My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
____	____	____	E9.	My headaches are so bad that I feel that I am going to go insane.
____	____	____	E10.	My outlook on the world is affected by my headaches.
____	____	____	E11.	I am afraid to go outside when I feel that a headaches is starting.
____	____	____	E12.	I feel desperate because of my headaches.
____	____	____	F13.	I am concerned that I am paying penalties at work or at home because of my headaches.
____	____	____	E14.	My headaches place stress on my relationships with family or friends.
____	____	____	F15.	I avoid being around people when I have a headache.
____	____	____	F16.	I believe my headaches are making it difficult for me to achieve my goals in life.
____	____	____	F17.	I am unable to think clearly because of my headaches.
____	____	____	F18.	I get tense (eg, muscle tension) because of my headaches.
____	____	____	F19.	I do not enjoy social gatherings because of my headaches.
____	____	____	E20.	I feel irritable because of my headaches.
____	____	____	F21.	I avoid traveling because of my headaches.
____	____	____	E22.	My headaches make me feel confused.
____	____	____	E23.	My headaches make me feel frustrated.
____	____	____	F24.	I find it difficult to read because of my headaches.
____	____	____	F25.	I find it difficult to focus my attention away from my headaches and on other things.

OTHER COMMENTS: _____

_____
Examiner

With permission from: Jacobson GP, Ramadan NM, et al. *The Henry Ford Hospital headache disability inventory (HDI).* Neurology 1994;44:837-842.

Indicate painful or distressed areas:
(i.e. pain, rash, spasms, sores, etc.)