

## 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

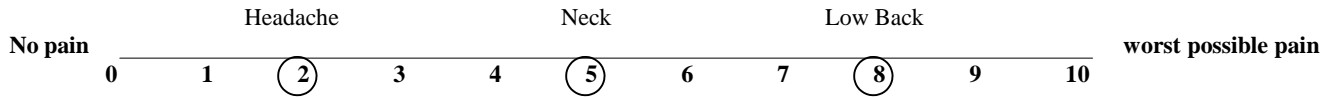
Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

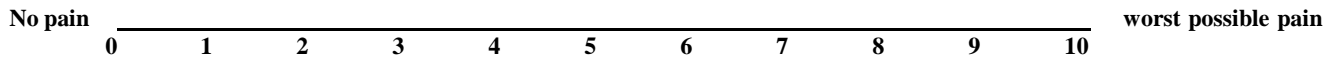
**Instructions:** Please circle the number that best describes the question being asked.

**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.

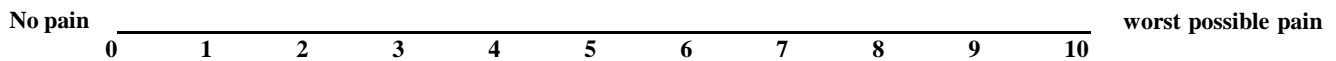
**Example:**



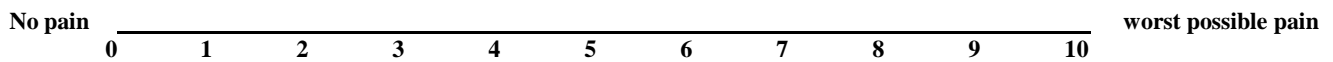
**1 – What is your pain RIGHT NOW?**



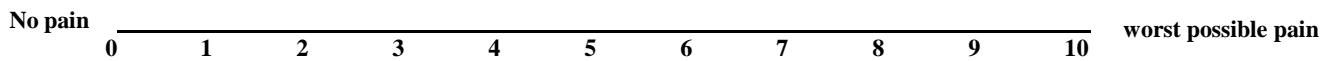
**2 – What is your TYPICAL or AVERAGE pain?**



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



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



**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

- | 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.)

