ACUPUNCTURE CENTER
for Family Health

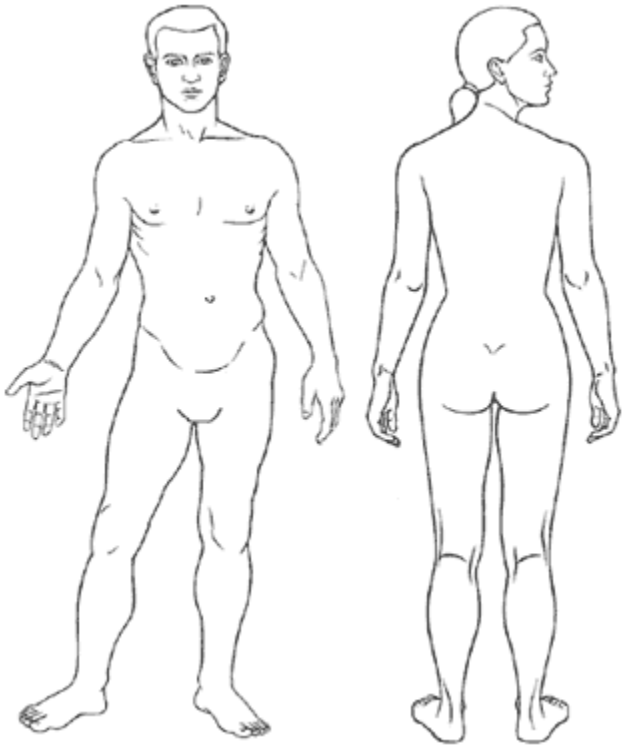
254 US Highway Rt. 202/206 ▯ Pluckemin, NJ 07978 ▯ (908)719-1362 ▯ www.acrh.net & www.acfamilyhealth.net

General Pain Index Questionnaire

Date: _____

Name: _____

Please mark areas of pain on diagrams.



Did the pain start from trauma? Yes or No

Is the pain:
Sharp, Cramping, Fixed, Burning, Dull, Aching, Moving, other _____

Does the following lessen the pain?
Pressure, Exercise, Cold, Heat, Rest, Other
_____

Does the following worsen the pain?
Pressure, Cold, Heat, Damp weather, other
_____

<u>Pain/Discomfort of main complaint:</u>

Least 1 2 3 4 5 6 7 8 9 10 Worst

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

Family/at-home responsibilities such as yard work, chores around the house

Able to function 0 1 2 3 4 5 6 7 8 9 10 Unable to function

Recreation including hobbies, sports or other leisure activities

Able to function 0 1 2 3 4 5 6 7 8 9 10 Unable to function

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

Able to function 0 1 2 3 4 5 6 7 8 9 10 Unable to function

Employment including volunteer work and homemaking tasks

Able to function 0 1 2 3 4 5 6 7 8 9 10 Unable to function

Self-care such as taking a shower, driving or getting dressed

Able to function 0 1 2 3 4 5 6 7 8 9 10 Unable to function

Life-support activities such as eating and sleeping

Able to function 0 1 2 3 4 5 6 7 8 9 10 Unable to function

SCORE _____ (60) Benchmark = 5 _____