Industrial Physical Therapy, Inc.

Dallas Pain Questionnaire

Please read carefully: This questionnaire has been designed to give your doctor information as to how your pain has affected your life. Be sure that these are your answers. Do not ask someone else to fill out the questionnaire for you. Please mark an "X" in the appropriate box that expresses your thoughts from 0 to 100 in each section.

Section I: Pain & Intensity
To what degree do you rely on pain medications or pain relieving substances for you to be comfortable?

None — Some — All the time
0% ☐☐☐☐☐☐ 100%

Section II: Personal Care
How much does pain interfere with your personal care (getting out of bed, teeth brushing, etc.)?

None (no pain) — Some — I cannot get out of bed
0% ☐☐☐☐☐☐ 100%

Section III: Lifting
How much limitation do you notice in lifting?

None (I can lift as I did) — Some — I cannot lift anything
0% ☐☐☐☐☐☐ 100%

Section IV: Walking
Compared with how far you could walk before your injury or back trouble, how much does pain restrict your walking now?

I can walk the same — Almost the same — Very little — I cannot walk
0% ☐☐☐☐☐☐ 100%

Section V: Sitting
Back pain limits my sitting in a chair to:

None same as before — Some — I cannot sit at all
0% ☐☐☐☐☐☐ 100%

Section VI: Standing
How much does your pain interfere with your tolerance to stand for long periods?

None same as before — Some — I cannot Stand
0% ☐☐☐☐☐☐ 100%

Section VII: Sleeping
How much does pain interfere with your sleeping?

None same as before — Some — I cannot sleep at all
0% ☐☐☐☐☐ 100%

Section VIII: Social life
How much does pain interfere with social life (dancing, games, going out, eating with friends, etc.)?

None same as before — Some — No activities total loss
0% ☐☐☐☐☐☐☐☐ 100%

Section IX: Traveling
How much does pain interfere with traveling in a car?

None same as before — Some — I cannot Travel
0% ☐☐☐☐☐☐☐ 100%

Section X: Vocational
How much does pain interfere with your job?

None no interference — Some — I cannot work
0% ☐☐☐☐☐☐☐☐ 100%

Section XI: Anxiety / Mood
How much control do you feel that you have over demands made on you?
(No Change)

Total — Some — None
0% ☐☐☐☐☐☐☐ 100%

Section XII: Emotional Control
How much control do you feel you have over emotion?
(No Change)

Total — Some — None
0% ☐☐☐☐☐☐☐☐ 100%

Section XIII: Depression
How depressed have you been since the onset of pain?

Not depressed significantly — Some — Overwhelmed by depression
0% ☐☐☐☐☐☐☐☐ 100%

Section XIV: Interpersonal Relationships
How much do you think your pain has changed your relationships with others?

Not Changed — Some — Drastically Changed
0% ☐☐☐☐☐☐☐☐ 100%

Section XV: Social Support
How much support do you need from others to help you during this onset of pain (taking over chores, fixing meals, etc.)?

None needed — Some — All the time
0% ☐☐☐☐☐☐☐ 100%

Section XVI: Punishing Response
How much do you think others express irritation, frustration or anger toward you because of your pain?

None — Some — All the time
0% ☐☐☐☐☐☐☐☐ 100%