DALLAS PAIN QUESTIONNAIRE

Name: ________________________  Today's Date: ________________________

Date of Birth: ________________________  Examiner: ________________________

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 1 to 100 in each section.

Section I: Pain and 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, dressing, etc.)?

None ________  Some ________  I cannot get out of bed ________

(No pain) ________  100% ________

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

None ________  Some ________  I cannot lift anything ________

(I can lift as I did) ________  100% ________

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

I can walk ________  Almost the same ________  Very little ________

the same ________  100% ________

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

None, pain ________  Some ________  I cannot sit at all ________

same as before ________  100% ________

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

None ________  Some ________  I cannot stand ________

same as before ________  100% ________

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

None ________  Some ________  I cannot sleep at all ________

same as before ________  100% ________

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

None ________  Some ________  No activities total loss ________

same as before ________  100% ________

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

None ________  Some ________  I cannot travel ________

same as before ________  100% ________

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

None ________  Some ________  I cannot work ________

No interference ________  100% ________

Section XI: Anxiety/Mood
How much control do you feel that you have over demands made on you?

(No change) ________  Some ________  None ________

Total ________  100% ________

Section XII: Emotional Control
How much control do you feel that you have over your emotions?

(No change) ________  Some ________  None ________

Total ________  100% ________

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

Not depressed significantly ________  Overwhelmed by depression ________

0% ________  100% ________

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

Not changed ________  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.)?

Not needed ________  All the time ________

0% ________  100% ________

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

None ________  Some ________  All the time ________

same as before ________  100% ________