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 0% — Some — All the time 100%

Section II: Personal Care

How much does pain interfere with your personal care (getting out of bed, teeth brushing, dressing, etc.)?

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

Section III: Lifting

How much limitation do you notice in lifting?

None (I can lift as I did) 0% — Some — I cannot lift anything 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 the same 0% — Almost the same — Very little — I cannot walk 100%

Section V: Sitting

Back pain limits my sitting in a chair to?

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

Section VI: Standing

How much does your pain interfere with your tolerance to stand for long periods?

None same as before 0% — Some — I cannot stand 100%

Section VII: Sleeping

How much does pain interfere with your sleeping?

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

Section VIII: Social Life

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

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

Section IX: Traveling

How much does pain interfere with traveling in a car?

None same as before 0% — Some — I cannot travel 100%

Section X: Vocational

How much does pain interfere with your job?

None No interference 0% — Some — I cannot work 100%

Section XI: Anxiety/Mood

How much control do you feel that you have over demands made on you?

(No change) Total 0% — Some — None 100%

Section XII: Emotional Control

How much control do you feel that you have over your emotions?

(No change) Total 0% — Some — None 100%

Section XIII: Depression

How depressed have you been since the onset of pain?

Not depressed significantly 0% — Overwhelmed by depression 100%

Section XIV: Interpersonal Relationships

How much do you think your pain has changed your relationships with others?

Not changed 0% — Drastically changed 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 0% — All the time 100%

Section XVI: Punishing Responses

How much do you think others express irritation, frustration, or anger toward you because of your pain?

None 0% — Some — All the time 100%