DALLAS PAIN QUESTIONNAIRE

Name_____

Date_____ Date of Injury_____

Please read: This questionnaire has been designed to give your health care provider information as to how your pain affects your daily activities. Be sure that these are your answers. Do not ask someone else to complete this questionnaire for you. Please mark an "X" along the line that expresses your thoughts from 0-100 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(no pain) Some I can't get out of bed
0%(_____:_____:_____:_____:_____:_____)100%

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

None Some I can't lift anything
0%(_____:_____:_____:_____:_____:_____)100%

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

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 Some I can't sit at all
0%(_____:_____:_____:_____:_____:_____)100%

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

None(same as before) Some I can't stand
0%(_____:_____:_____:_____:_____:_____)100%

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

None(same as before) Some I can't sleep at all
0%(_____:_____:_____:_____:_____)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
0%(____:____:_____:_____:_____:_____:____:____)100%

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

None Some I can't travel
0%(_____:_____:_____:_____:_____:_____:_____)100%

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

None Some I can't work
0%(____:_____:_____:_____:_____:_____:____:____)100%

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

Total (no change) Some
None
0%(_____:_____:_____:_____:_____:_____:_____)100%

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

Total (no change) Some
None
0%(____:_____:_____:_____:_____:_____:____:____)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, meals, etc)?

None needed 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%

I-VIIx3=_____ VIII-Xx5=_____ XI-XIIIx5=_____ XIV-XVIx5=_____