CPM Intake Questionnaire

PATIENT DEMOGRAPHIC INFORMATION

Date: ______________________________ Health Card #:_________________________________

❒ Dr. ❒ Miss ❒ Mr. ❒ Mrs. ❒ Ms.

First Name: _________________ Middle Name: _______________ Last Name:____________________

Date of Birth: (YY/MM/DD) ______/________/________ Gender: ❒ Female ❒ Male

Address: _________________________ City:_____________ Province:______ Postal Code: ____

Preferred Method of Contact: ❒Phone❒ Email

Tel No: Home: (____)______-_______ Mobile: (____)______-_______ Work: (____)______-_______

E-mail: __________________________________ Referral Source: _________________________________

Marital Status: _________________________ Preferred Language: _________________________________

Occupational Status

Employer/School ___________________________ Occupation _________________________/ ❒ Student

Status: ❒Full-time ❒ Part-time ❒Self-Employed ❒ Retired ❒ Seasonal ❒ Unemployed

Emergency Information

Emergency contact: _______________________________ Relationship: ____________________________

Tel. No.:(____)______-_______ Name of Guardian (if applicable):________________________________

Insurance Information

Is your pain related to: ❒WSIB ❒Motor Vehicle Accident ❒ Disability (STD/LTD/ODSP)

If yes to any of the above, please provide the Claim No.:______________________________________

Do you have Extended Health Benefits? ❒Yes ❒No

Do you have extended health coverage from another family member? ❒Yes ❒No

Insurance Provider: __________________________ **Employer:** _____________________________

Policy/Contract Number: _________________**Client ID Number:** ___________________________

Service	%	Annual Maximum	Initial Consult	Subsequent Visit	Deductible	Requires Referral
Physiotherapy						❒ Yes ❒ No
Chiropractic						❒ Yes ❒ No
Drug Plan						❒ Yes ❒ No
Orthotics						❒ Yes ❒ No
Naturopathy						❒ Yes ❒ No
Massage						❒ Yes ❒ No
Other Services						

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Pain History

Major Pain Complaint:____

How did it happen?:____

How long have you had this condition: _____Years _____ Months _____ Weeks

Other pain complaint(s):____

Approximately, how many days during the last **month** were you in pain? (0-30) __________________

How has your pain changed over the last **month**? ❒Getting Better ❒No Change ❒Getting Worse

How persistent was the pain during an **average day** in the last **week**? ❒Always present ❒ Intermittent

What things make it worse? ____

What things make it better? ____

Are you presently taking prescription medication? ❒Yes ❒No

If "Yes" please bring your complete medication print out from your pharmacy next visit.

Are you currently taking your medication as prescribed by your physician? ❒Yes ❒No

Are you presently taking non-prescription/ over the counter medication? ❒Yes ❒No

If "Yes" please provide a list of non-prescription/over the counter medication you're taking.

Have you tried any of the treatments below for your pain? ❒Yes ❒No

If "Yes" please complete below			
	When was it?	For how long?	Helpful? (yes/no)
Acupuncturist			
Chiropractor			
Physiotherapist			
Psychologist			
Meditation/Yoga			
Exercise			
Other:			

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Past Medical History

Please list any other health problems (other than pain problems) that you currently have:

Year of Onset — Type of Problem and Treatment

__________________ ____

__________________ ____

Please list any other serious health problems or major illnesses you have had in the past:

Date — Type of Problem or Illness

__________________ ____

__________________ ____

Are you scheduled for surgery or any other medical procedures **for your pain**? ❒Yes ❒No

If yes, please state what the procedure is and when you expect to have it done: _____________________

____

Please list any surgery you have had that was **NOT** related to your pain:

Date — Type of Surgery

__________________ ____

__________________ ____

Family Medical History

If any of your family members have major medical problems, please list them here. Include headaches, pain problems, arthritis, unusual joint flexibility, cancer, heart disease, stroke, high blood pressure, diabetes, seizures, addiction problems, mental health problems and others.

Relationship to you	Medical Problem

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Lifestyle Information

Height: ____________ cm/ in Weight: ____________ lbs/ kg BMI:___________

Do you walk (or do other moderate activity) for at least 30 minutes at least 3 days a week? ❒Yes ❒No
Would this be something you would like to improve? ❒Yes ❒No

Without wanting to, have you lost or gained 10 pounds or more in the last 6 months? ❒Yes ❒No

Do you eat fewer than two meals per day? ❒Yes ❒No

Do you have any food intolerances or sensitivities? ❒Yes ❒No

Do you have any food allergies? ____

How many foods do you limit/avoid because of a health condition?

❒None ❒One or two ❒Quite a few ❒It's difficult to eat with others ❒My diet is very restricted

Have you ever been told you had diabetes or a problem with high blood sugar? ❒Yes ❒No

Have you ever been told your total cholesterol level is high? ❒Yes ❒No

Have you ever been told you have high blood pressure or have you ever been given blood pressure medication? ❒Yes ❒No

Do you eat 3 or more servings of whole grains per day (wheat bread, whole grain pasta, brown rice, oatmeal, whole grain breakfast cereal, bran or popcorn)? A serving is one slice of bread, 1 ounce of breakfast cereal or ½ cup of cooked cereal, pasta or rice ❒Yes ❒No

Do you eat more than 3 servings of refined starch per day (while bread, white rice, white pasta, white potatoes, or low fibre cereals)? A serving is one slice of bread, 1 ounce of breakfast cereal or ½ cup of cooked cereal, pasta or rice ❒Yes ❒No

Do you eat oil-based salad dressing or use liquid vegetable oil for cooking on most days? ❒Yes ❒No

Do you eat 5 or more servings of fruit and vegetables per days? A serving is one medium apple, banana or orange, 1 cup of raw leafy vegetable (like spinach or lettuce), ½ cup of cooked beans or peas, ½ of chopped, cooked or canned fruit/vegetable or ¾ cup of fruit/vegetable juice. ❒Yes ❒No

Do you usually eat 3 servings of nuts per week? A serving is 1 ounce, which is about one airline packet of nuts or one tablespoon of peanut butter ❒Yes ❒No

Do you usually eat fish twice or more times a week? ❒Yes ❒No

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Do you usually eat butter, lard, red meat, cheese or whole milk 2 or more times a week? ❒Yes ❒No

Do you eat stick Margarine, vegetable shortening, store bought baked goods or deep-fried fast foods on most days? ❒Yes ❒No

Do you take any type of vitamin supplement on most days? ❒Yes ❒No

Do you have any medication allergies? ❒Yes ❒No

If Yes, please list all medication allergies and the reaction that resulted:

____

____

____

How many cups of tea or coffee do you drink per day? __________ caffeinated soft drinks? ___________

Do you smoke? ❒ No ❒ Less than ½ pack a day ❒ ½ pack to 1 pack a day ❒ 1 or more pack a day

Are you exposed to smoke from other people smoking? ❒ Never ❒ Occasionally ❒ Regularly

At what age did you first start smoking? __________

If you have tried to quit smoking in the past, what is the longest time you have quit?________________

If you smoke, how soon after waking up do you smoke your first cigarette?

❒ as soon as I get up ❒ within 30 mins. ❒ within the first hour ❒ after the first hour of waking up

How often do you have a drink containing alcohol? _________ times a week; _______times a month

How many servings of alcohol do you have on a typical day? One serving is a can or bottle of beer, a glass of wine or a shot of liquor. ❒0 drinks ❒ 1 drink ❒2 drinks ❒ 3 or more drinks

How often did you have 3 or more drinks on one occasion in the past year?

❒Never ❒Less than Monthly ❒Monthly ❒Weekly ❒Daily or almost daily

At what age did first started drinking?____

Did you ever feel that you should cut down or change your drinking or drug use? ❒Yes ❒No

Have you ever used prescription drugs to get a high or "buzz" (even as a young person)? ❒Yes ❒No

Have you ever attended meetings of AA, NA, CA, or other similar self-help group? ❒Yes ❒No

Have your family members or friends ever been worried about your drinking or drug use? ❒Yes ❒No

Have you ever had any legal consequences due to drug or alcohol use (i.e., arrests, driving while impaired)? ❒Yes ❒No

Do you currently smoke marijuana? ❐Yes ❐No

If yes, do you use it mostly for pain or to calm you down? ❐Pain ❐Calms me down ❐Recreational

If yes, how many grams or joints per day do you smoke? ___ joints or ____ grams per day

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons? Never___ 1-2 times ____ 3-4 times____ 5-10 times____ More than 10 times____

Pain and Sleep

PSQ-3

Thinking back over the last week, how has pain affected your sleep? For each of the following questions choose a number between 0 and 10 that applies to the quality of your sleep.

1. How often have you had trouble falling asleep because of pain?

   Never 0 1 2 3 4 5 6 7 8 9 10 Always

2. How often have you been awakened by pain during the night?

   Never 0 1 2 3 4 5 6 7 8 9 10 Always

3. How often have you been awakened by pain in the morning?

   Never 0 1 2 3 4 5 6 7 8 9 10 Always

Have you ever been tested for sleep apnea? ❐Yes ❐No
If Yes, were you prescribed a CPAP machine? ❐Yes ❐No
If Yes, do you use it every night? ❐Yes ❐No

STOP-BANG Screen

1. ***S***noring: Do you snore loudly (loud enough to be heard through closed doors)?
   Yes No
2. ***T***ired: Do you often feel tired, fatigued, or sleepy during daytime?
   Yes No
3. ***O***bserved: Has anyone observed you stop breathing during your sleep?
   Yes No
4. Blood ***P***ressure: Do you have or are you being treated for high blood pressure?
   Yes No
5. ***B***MI: BMI more than 35 kg/m^2? Yes No
6. ***A***ge: Age over 50 years old? Yes No
7. ***N***eck circumference greater than 40 cm? Yes No
8. ***G***ender: Male? Yes No

ESS

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

SITUATION	CHANCE OF DOZING (0–3)
Sitting and reading	
Watching television	
Sitting inactive in a public place (e.g. a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
TOTAL SCORE	

Pain and Work

Check as many as apply. **At the present time** are you:

_____ 1. Working full-time for someone else?
_____ 2. Working part-time for someone else?
_____ 3. Self-employed full-time for?
_____ 4. Self-employed part-time?
_____ 5. The main one taking care of the home?
_____ 6. The main one taking care of the children?
_____ 7. Retired? If yes, for how long? _____________
_____ 8. Unemployed If yes, for how long? ____________

If you are presently working, please describe your work.

____

If you are currently unemployed, retired, or working part-time, is this due to your pain condition?

❒ Yes ❒ No

If yes, how has pain interfered with your ability to work ? (please be specific)

____

If you are not working at present, have you tried to return to work (either to a previous job or starting a new one)? ❐ Yes ❐ No

If yes, when? ______________________________

What type of work? ______________________________

For how long? ______________________________

What happened? ______________________________

How long can you usually do each of the following activities before you have to stop and what is the main reason that limits you? Give your answer in **hours and/or minutes**.

	Hours	Minutes	Pain	Fatigue	Other Reasons
Sitting	_______	_______	_____	_____	____________________
Walking	_______	_______	_____	_____	____________________
Standing	_______	_______	_____	_____	____________________
Reading	_______	_______	_____	_____	____________________
Driving	_______	_______	_____	_____	____________________

Are you presently concerned about financial problems or major debts? ❐ Yes ❐ No

Please explain: ______________________________

What are your present sources of income? ______________________________

In the past, have you received any financial benefits or compensation for your pain or injury?

❐ Yes ❐ No If yes, what kind? ______________________________

Are you presently applying for financial benefits or compensation resulting from your pain or injury?

❐ Yes ❐ No If yes, what kind? ______________________________

Are you presently involved in legal action that is related to your pain or injury? ❐ Yes ❐ No

If yes, what is the nature of this action? ______________________________

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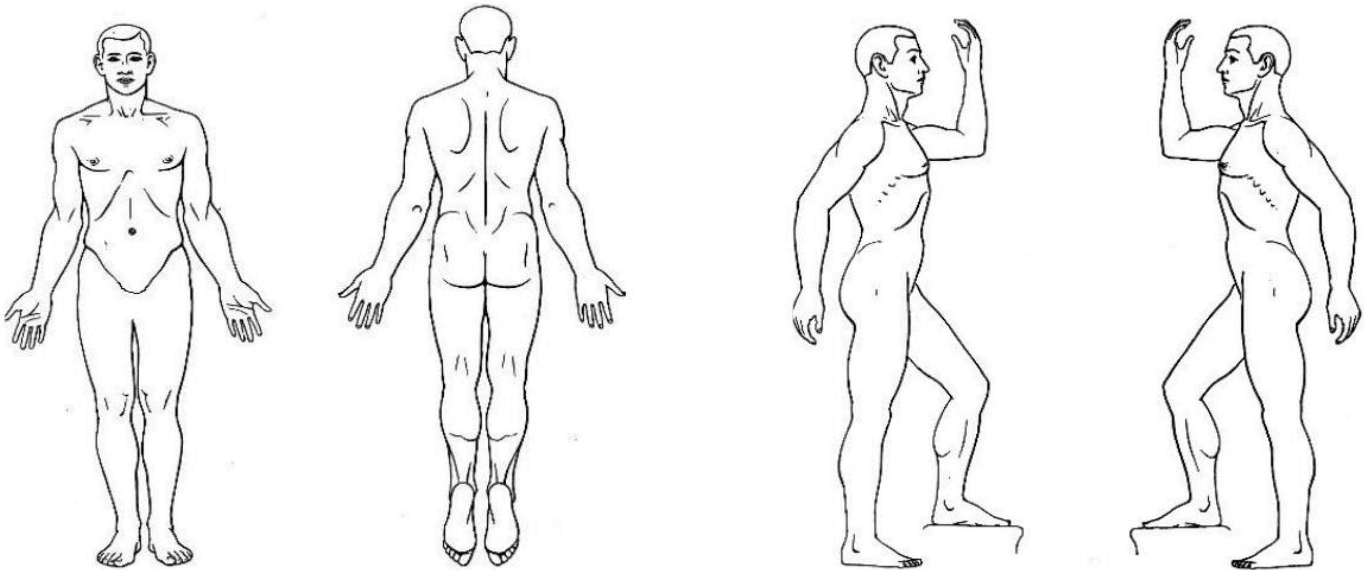
Pain Diagram and Pain Scale

Mark the areas on the diagram below that coincide with your pain. Include ALL affected areas. Use as many individual symbols as you'd like to describe the pain. Indicate shooting pain by drawing an arrow (→) from the origin of pain to where it ends.

Use the appropriate symbol(s) listed below.

ACHING	XXXX XXXX	NUMBNESS	==== ====	PINS AND NEEDLES	0000 0000
BURNING	>>>> >>>>	STABBING	//// ////	THROBBING	+ + + + + + + +



On a scale of 0-10, please indicate how you feel in each scenario

1. Please circle the one number that best describes your **WORST** pain in the past 7 days.

   No pain 0 1 2 3 4 5 6 7 8 9 10 The worst pain imaginable

2. Please circle the one number that best describes your **LEAST** pain in the past 7 days.

   No pain 0 1 2 3 4 5 6 7 8 9 10 The worst pain imaginable

3. Please circle the one number that best describes your **AVERAGE** pain most of the time.

   No pain 0 1 2 3 4 5 6 7 8 9 10 The worst pain imaginable

4. Please rate your pain by circling the one number that tells how much pain you have **RIGHT NOW**

   No pain 0 1 2 3 4 5 6 7 8 9 10 The worst pain imaginable

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Systems Review

Please put an "X" in the circles for all areas where you currently have (or once had) problems. Write the year when you had it beside the condition.

HEAD/NECK
O glaucoma
O eye/vision problems
O hearing or balance problems
O nose/sinus problems
O throat/neck problems
O jaw/teeth problems
O other ________________

SKIN
O rashes
O sores/ulcers
O eczema/allergic dermatitis
O other ________________

MUSCLES/BONES/JOINTS
O broken bones
O arthritis
O joint swelling or stiffness
O very flexible; "double jointed"
O muscle pain
O fatigue
O morning stiffness
O other ________________

OB/GYN
O pelvic pain
first menstrual period at age _____
date last menstrual period began ______
O menstrual problems
O menopause

PSYCHOLOGICAL
O depression
O anxiety/panic
O suicide attempt
O psychiatric hospitalization
O schizophrenia or bipolar disorder
O counselling
O victim of abuse/neglect
O other _____________________

LUNGS/CHEST
O Shortness of breath
O cough
O chest pains
O asthma/emphysema
O hay fever/allergies
O pneumonia
O other _______________

NERVES/BRAIN
O headache
O dizziness
O seizures
O stroke
O brain injury
O spinal cord injury
O tremor
O double vision
O loss of consciousness
O brain tumor
O multiple sclerosis
O other _______________

CONSTITUTIONAL
O fevers
O chills
O night sweats
O weight loss
O weight gain
O other _______________

STOMACH/ABDOMEN
O heartburn or ulcers
O diarrhea
O constipation
O trouble swallowing
O loss of bowel control
O red or black in stools
O nausea or vomiting
O stomach upset from meds
O irritable bowel syndrome

URINARY/GENITAL
O kidney stones
O urinary infections
O kidney failure/dialysis
O trouble urinating
O loss of urine control
O sexual difficulties
O other _______________

CARDIOVASCULAR
O high blood pressure
O heart surgery
O chest pains/angina
O heart attack
O heart murmur
O irregular heartbeat
O blood clots in legs/arms
O mitral valve prolapse
O non-healing sores
O poor circulation
O leg or arm swelling
O other ________________

SPINE
O neck injury or pain
O back injury or pain
O disc disease
O fracture
O scoliosis
O other _______________

OTHER
O anemia ("low blood")
O swollen glands or nodes
O cancer
O easy bleeding/bruising
O transfusions
O nasal polyps
O transplant patient
O food allergies
O other _______________

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S-LANSS

Please circle NO or YES below to describe your pain.

1. **In the area where you have pain, do you also have 'pins and needles', tingling or prickling sensations?**
   a. NO - I don't get these sensations (0)
   b. YES - I get these sensations often (5)

2. **Does the painful area change colour (perhaps looks mottled or more red) when the pain is particularly bad?**
   a. NO - The pain does not affect the colour of my skin (0)
   b. YES - I have noticed that the pain does make my skin look different from normal (5)

3. **Does your pain make the affected skin abnormally sensitive to touch? Getting unpleasant sensations or pain when lightly stroking the skin might describe this.**
   a. NO - The pain does not make my skin in that area abnormally sensitive to touch (0)
   b. YES - My skin in that area is particularly sensitive to touch (3)

4. **Does your pain come on suddenly and in bursts for no apparent reason when you are completely still? Words like 'electric shocks', jumping and bursting might describe this.**
   a. NO - My pain doesn't really feel like this (0)
   b. YES – I get these sensations often (2)

5. **In the area where you have pain, does your skin feel unusually hot like a burning pain?**
   a. NO - I don't have burning pain (0)
   b. YES – I get burning pain often (1)

6. **Gently rub the painful area with your index finger and then rub a non-painful area (for example, an area of skin further away or on the opposite side from the painful area). How does this rubbing feel in the painful area?**
   a. The painful area feels no different from the non-painful area (0)
   b. I feel discomfort, like pins and needles, tingling or burning in the painful area that is different from the non-painful area (5)

7. **Gently press on the painful area with your finger tip then gently press in the same way onto a non-painful area (the same non-painful area that you chose in the last question). How does this feel in the painful area?**
   a. The painful area does not feel different from the non-painful area (0)
   b. I feel numbness or tenderness in the painful area that is different from the non-painful area (3)

Total:________________

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Coping Strategies Questionnaire

People who experience pain have developed a number of ways to cope, or deal with, their pain. These include saying things to yourself when you experience pain, or doing a different activity. Below is a list of things that people have reported doing when they feel pain. For each activity, please indicate, using the scale below, how much you engage in that activity when you feel pain, where a 0 indicates you never do this when you are experiencing pain, a 3 indicates you sometimes do this when you are experiencing pain, and a 6 indicates you always do this when you are experiencing pain. Remember, you can use any point along the scale.

When I feel pain …

	Never do						Always do	
1. I think of things I enjoy doing ……………………………………………	0	1	2	3	4	5	6	DivAt
2. I just think of it as some other sensation, such as numbness …………………	0	1	2	3	4	5	6	RePS
3. It is terrible and I feel it is never going to get any better ………………………	0	1	2	3	4	5	6	Cat
4. I don't pay any attention to it ………………………………………………	0	1	2	3	4	5	6	IPS
5. I pray for the pain to stop …………………………………………………	0	1	2	3	4	5	6	PrH
6. I tell myself I can't let the pain stand in the way of what I have to do ………	0	1	2	3	4	5	6	CSS
7. I do something active, like household chores or projects ………………………	0	1	2	3	4	5	6	IBA
8. I replay in my mind pleasant experiences in the past …………………………	0	1	2	3	4	5	6	DivAt
9. I pretend it is not a part of me ……………………………………………	0	1	2	3	4	5	6	RePS
10. I feel I can't stand it anymore ……………………………………………	0	1	2	3	4	5	6	Cat
11. I ignore it ……………………………………………………………	0	1	2	3	4	5	6	IPS
12. I try to think years ahead, what everything will be like after I've gotten rid of the pain …………………………………………………………	0	1	2	3	4	5	6	PrH
13. I see it as a challenge and don't let it bother me…………………………	0	1	2	3	4	5	6	CSS
14. I do something I enjoy, such as watching TV or listening to music …………	0	1	2	3	4	5	6	IBA

PCS

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

When I'm in pain …	**Not at all**				**All the time**
1. I worry all the time about whether the pain will end ………	0	1	2	3	4
2. I feel I can't go on………………………………………………	0	1	2	3	4
3. It's terrible and I think it's never going to get any better….	0	1	2	3	4
4. It's awful and I feel that is overwhelms me ……………………	0	1	2	3	4
5. I feel I can't stand it anymore………………………………	0	1	2	3	4
6. I become afraid that the pain will get worse …………………	0	1	2	3	4
7. I keep thinking of other painful events………………………	0	1	2	3	4
8. I anxiously want the pain to go away ………………………	0	1	2	3	4
9. I can't seem to keep it out of my mind………………………	0	1	2	3	4
10. I keep thinking about how much it hurts……………………	0	1	2	3	4
11. I keep thinking about how badly I want the pain to stop….	0	1	2	3	4
12. There's nothing I can do to reduce the intensity of the pain	0	1	2	3	4
13. I wonder whether something serious may happen …………	0	1	2	3	4

Total Score: / 52

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HADS

Pease read Please read each statement below and circle the number which best describes how true the feeling is for you.

	Yes definitely	Yes sometimes	No, not much	No, not at all
1. I wake early and then sleep badly for the rest of the night.	3	2	1	0
2. I get very frightened or have panic feelings for apparently no reason at all.	3	2	1	0
3. I feel miserable and sad.	3	2	1	0
4. I feel anxious when I go out of the house on my own.	3	2	1	0
5. I have lost interest in things.	3	2	1	0
6. I get palpitations, or sensations of 'butterflies' in my stomach or chest.	3	2	1	0
7. I have a good appetite.	0	1	2	3
8. I feel scared or frightened.	3	2	1	0
9. I feel life is not worth living.	3	2	1	0
10. I still enjoy the things I used to.	0	1	2	3
11. I am restless and can't keep still.	3	2	1	0
12. I am more irritable than usual.	3	2	1	0
13. I feel as if I have slowed down.	3	2	1	0
14. Worrying thoughts constantly go through my mind.	3	2	1	0

A Score =2 + 4 + 6 + 8 + 11+ 12 +14

D Score = 1 + 3 + 5 + 7 + 9 + 10 + 13

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PDI

The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the *overall* impact of pain in your life, not just when the pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale, which describes the level of disability you typically experience. A score of 0 *means no disability at all,* and a score of 10 *signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.*

Family / home responsibilities: activities related to the home or family including chores or duties performed around the house (e.g., yard work) and errands for other family members (e.g., driving the children to school).

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Recreation: hobbies, sports, and other similar leisure time activities.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Social Activity: activities which involve participation with friends and acquaintances other than family members and includes : parties, theater, concerts, dining out, and other social functions.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Occupation: This category refers to activities that are a part of or directly related to one's job and includes non-paying jobs as well, such as that of a home-maker or volunteer worker.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Self-Care: This category includes activities which involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed, etc.).

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Life-support Activity: This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Total Score: _____/70

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General Health and Well-Being Questionnaire – SF12v2

For each of the questions below mark an "X" in the one box that best describes your answer.

1. In general how would you say your health is:
Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐

2. The following questions are about activities you might do during a typical day. Does **your health now limit** you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, golfing, etc.			
Climbing **several** flights of stairs			

3. During the ***past 4 weeks***, have you had any of the following problems with your work or other regular daily activities as a result of your ***physical health***?

	All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
Accomplished less than you would like?					
Were limited in the **kind** of work or other activities?					

4. During the ***past 4 weeks***, have you had any of the following problems with your work or other regular daily activities *as a result of any* ***emotional problems*** (such as feeling depressed or anxious)?

	All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
Accomplished less than you would like?					
Did work or other activities **less carefully than usual**?					

5. During the ***past 4 weeks***, how much did ***pain*** interfere with your normal work (including both work outside the home and housework)?
Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely ☐

6. These questions are about how you feel and how things have been with you ***during the past 4 weeks***. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the ***past 4 weeks*** …

	All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
Have you felt calm and peaceful?					
Did you have a lot of energy?					
Have you felt downhearted and depressed?					

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc)?
All of the time ☐ Most of the time☐ Some of the time ☐ A little of the time ☐ None of the time ☐