

**HEADACHE DISABILITY INDEX**

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**INSTRUCTIONS:** Please CIRCLE the correct response:

- 1. I have headache: (1) 1 per month      (2) more than 1 but less than 4 per month      (3) more than one per week
- 2. My headache is: (1) mild                      (2) moderate                                      (3) severe

**Please read carefully:** The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

| YES   | SOMETIMES | NO    |  |
|-------|-----------|-------|--|
| _____ | _____     | _____ | E1. Because of my headaches I feel handicapped.  |
| _____ | _____     | _____ | F2. Because of my headaches I feel restricted in performing my routine daily activities.                               |
| _____ | _____     | _____ | E3. No one understands the effect my headaches have on my life.  |
| _____ | _____     | _____ | F4. I restrict my recreational activities (eg, sports, hobbies) because of my headaches.                               |
| _____ | _____     | _____ | E5. My headaches make me angry.  |
| _____ | _____     | _____ | E6. Sometimes I feel that I am going to lose control because of my headaches.  |
| _____ | _____     | _____ | F7. Because of my headaches I am less likely to socialize.   |
| _____ | _____     | _____ | E8. My spouse (significant other), or family and friends have no idea what I am going through because of my headaches. |
| _____ | _____     | _____ | E9. My headaches are so bad that I feel that I am going to go insane.  |
| _____ | _____     | _____ | E10. My outlook on the world is affected by my headaches.  |
| _____ | _____     | _____ | E11. I am afraid to go outside when I feel that a headaches is starting.   |
| _____ | _____     | _____ | E12. I feel desperate because of my headaches.   |
| _____ | _____     | _____ | F13. I am concerned that I am paying penalties at work or at home because of my headaches.                             |
| _____ | _____     | _____ | E14. My headaches place stress on my relationships with family or friends.   |
| _____ | _____     | _____ | F15. I avoid being around people when I have a headache.   |
| _____ | _____     | _____ | F16. I believe my headaches are making it difficult for me to achieve my goals in life.                                |
| _____ | _____     | _____ | F17. I am unable to think clearly because of my headaches.   |
| _____ | _____     | _____ | F18. I get tense (eg, muscle tension) because of my headaches.   |
| _____ | _____     | _____ | F19. I do not enjoy social gatherings because of my headaches.   |
| _____ | _____     | _____ | E20. I feel irritable because of my headaches.   |
| _____ | _____     | _____ | F21. I avoid traveling because of my headaches.  |
| _____ | _____     | _____ | E22. My headaches make me feel confused.   |
| _____ | _____     | _____ | E23. My headaches make me feel frustrated.   |
| _____ | _____     | _____ | F24. I find it difficult to read because of my headaches.  |
| _____ | _____     | _____ | F25. I find it difficult to focus my attention away from my headaches and on other things.                             |

**OTHER COMMENTS:** \_\_\_\_\_

\_\_\_\_\_  
Examiner

## NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Instructions:** The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

\_\_\_\_\_  
Examiner

**OTHER COMMENTS:** \_\_\_\_\_

## QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name \_\_\_\_\_

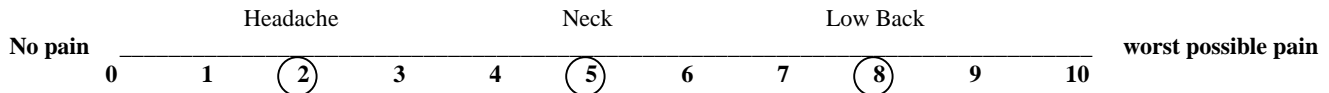
Date \_\_\_\_\_

**Please read carefully:**

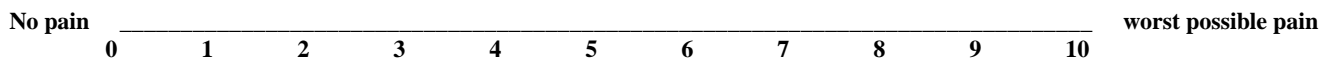
**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

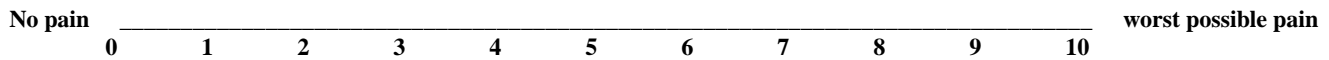
**Example:**



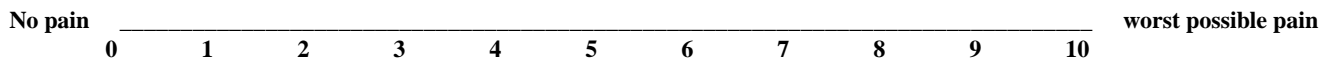
**1 – What is your pain RIGHT NOW?**



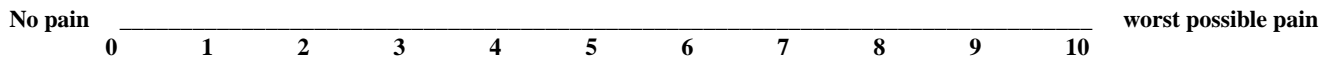
**2 – What is your TYPICAL or AVERAGE pain?**



**3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?**



**4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?**



**OTHER COMMENTS:**

---

---

Examiner \_\_\_\_\_

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

## PAIN DISABILITY QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Instructions:** These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?  
Work normally Unable to work at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
2. Does your pain interfere with personal care (such as washing, dressing, etc.)?  
Take care of myself completely Need help with all my personal care  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
3. Does your pain interfere with your traveling?  
Travel anywhere I like Only travel to see doctors  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
4. Does your pain affect your ability to sit or stand?  
No problems Can not sit/stand at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?  
No problems Can not do at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?  
No problems Can not do at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
7. Does your pain affect your ability to walk or run?  
No problems Can not walk/run at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
8. Has your income declined since your pain began?  
No decline Lost all income  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
9. Do you have to take pain medication every day to control your pain?  
No medication needed On pain medication throughout the day  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
10. Does your pain force you to see doctors much more often than before your pain began?  
Never see doctors See doctors weekly  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?  
No problem Never see them  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
12. Does your pain interfere with recreational activities and hobbies that are important to you?  
No interference Total interference  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?  
Never need help Need help all the time  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
14. Do you now feel more depressed, tense, or anxious than before your pain began?  
No depression/tension Severe depression/tension  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?  
No problems Severe problems  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

\_\_\_\_\_  
Examiner

**OTHER COMMENTS:**

With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.