

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (Please Print): _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____

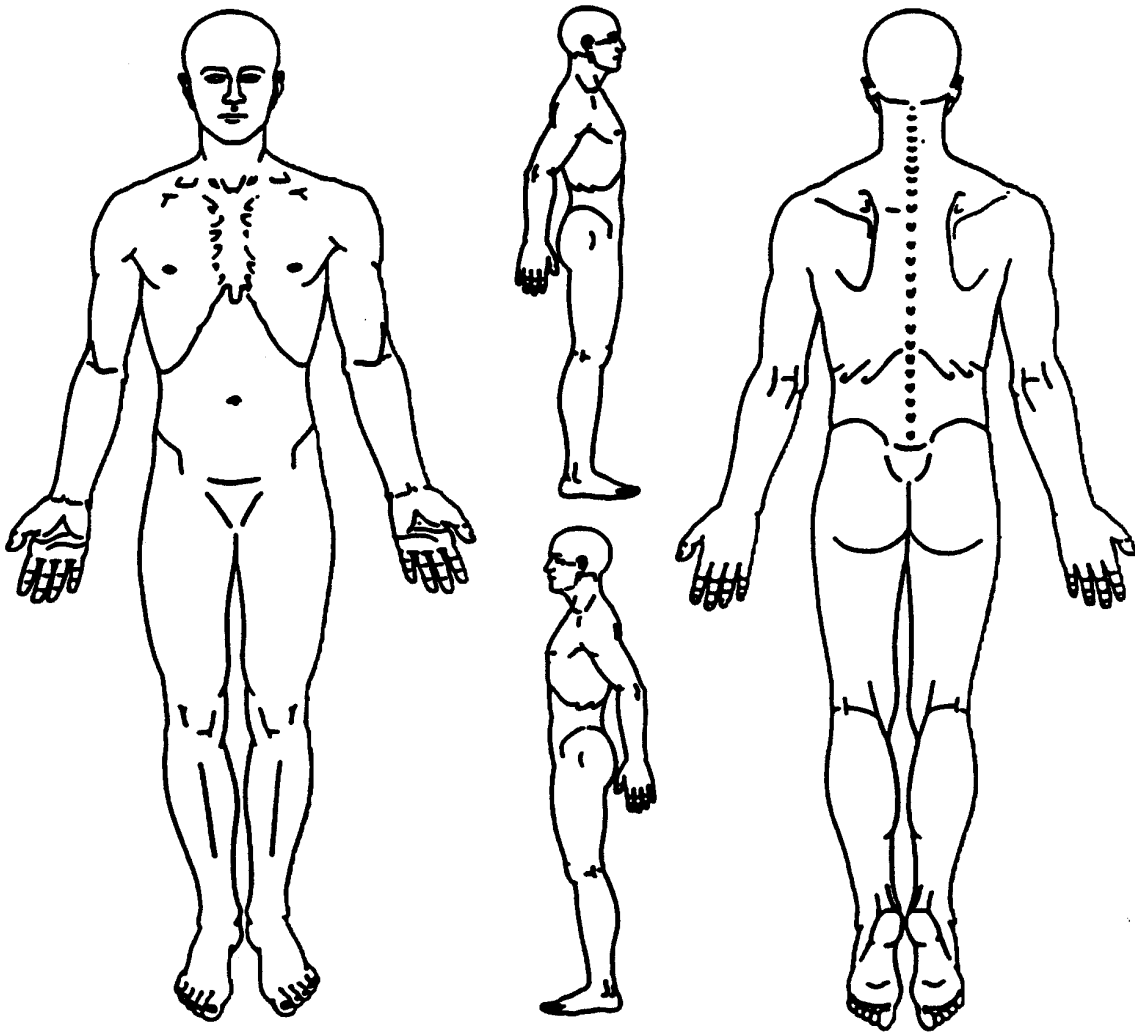
HOW LONG HAVE YOU HAD THIS PAIN? _____ YEARS _____ MONTHS _____ WEEKS

IS THIS YOUR FIRST EPISODE OF THIS PAIN? _____ YES _____ NO

USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form)

KEY: A = ACHE B = BURNING N = NUMBNESS
 P = PINS & NEEDLES S = STABBING O = OTHER



OVER PLEASE

For Doctor's Use:

Chief complaint (other than neck or low back pain): _____

(For neck conditions use the Neck Disability Index Questionnaire; for lower back conditions use the Roland-Morris or the Oswestry Low Back Pain Disability Questionnaire.)

