Fibromyalgia Pain Functional Questionnaire

To:					
Re:	(Name of patient) (Social Security Number)				
Please answer the following:					
1. How long have you been s	eeing your doctor with Fibromyalgia symptoms?				
2. List any other diagnosed in	mpairments or coexisting conditions:				
3. Can your impairements beYN	expected to last at least 12 months?				
4. What test, laboratory and o	clinical testings show your medical impairments:				
5. Check all that apply to you	1:				
Multiple tender points	Numbness and tingling				
Nonrestorative sleep	Sicca symptoms				
Chronic fatigue	Morning stiffness				
Subjective swelling	Irritable bowel syndrome				
Depression	Mitral valve prolapse				
Hypothyroidism	Vestibular dysfunction				
Lack of coordination	Cognitive impairment*				
Multiple trigger points	Raynaud's phenomenon				
Dysmenorrhea	Do you feel anxious				

Panic attacksUrinary tract infectionsCarpal tunnelTMJ DysfunctionDifficulty communicatBalance problems Shortness of breath	ing	_Frequent sever headaches _Premenstrual syndrome _Chronic fatigue syndrome _Myofascial pain syndrome _Dizziness _Headaches or migraines _Multiple chemical sensitivity
Stress incontinence		Free-floating anxiety
Mood swings		_Unaccountable irritability
Sensitivity to cold, hea	t, humidity, noise	
Problems climbing/go	ing up stairs	
inability to deal wi	y impairment problems ng into space befo	ore the brain can function). Ty stimuli/multitasking.
Where is your pain?		
Lower back Face	Mid-back Chest	Upper back Head
	Right	Left
Shoulders		
Arms		
Hands		
Hips		
Legs		
Knees		
Ankles		
Feet		

8. Describe the nature, frequency, and severity of this pain:
What factors make your pain worse?FatigueOver use/movementColdHeatChanging weatherStressHormonal changesHumiditySitting stillAllergyList other:
9. How often does your pain sufficiently severe to interfere with attention and concentration?NeverSeldomOftenFrequentlyConstantly
10. Do you find yourself limited in your ability to cope with stress at work? No limitationsSlight limitationsModerate limitations Marked limitationsSevere limitations
11. Do your side effects from your medicine cause limits at work? (dizziness, or stomach upset)
How long can you sit without experiencing delayed pain/symptoms?
13. How long can you stand/walk without pain or delayed symptoms?
14. Do you need to include periods of walking during an 8-hour day? Yes No Cannot work 8-hour
15.Do you need to lie down at unpredictable intervals during a 4 hr shift?
16. With prolonged sitting do you need to have you legs up?Yes NoCannot tolerate prolonged sitting
17. While standing or walking, do you need a cane or other device? Yes

18.How much weight sh suffering delayed onset syr	•	rry within a norm	nal work situation, without
Less than 10 lbs 10 lbs 20 lbs 50 lbs	Never	Occasionally* —— —— *less than 1/3 workday	
19. Do you have signific fingertips? Yes		~	g or handling, or using you
20. If you do, how long of hands – grasp, hands – grasp, fingers – detail arms – reaching fine motor confidence are y getting treatment or treatment.	twist - ed work_ g, overhead trol you been abs	Right% Le Right% Le Right% Le Yes No ent from work be	eft% eft% eft% eft% cause of your disabilities o
22. What are the limitation	ons that wou	ld make it impos	sible to work a regular job?
3. Check all the complaing anklessciaticaanxiety	_buckling ki _muscle twi	neesleg cra tching	-
Date:	_ Signed:		
Print name:			