

# General Pain Disability Index Questionnaire

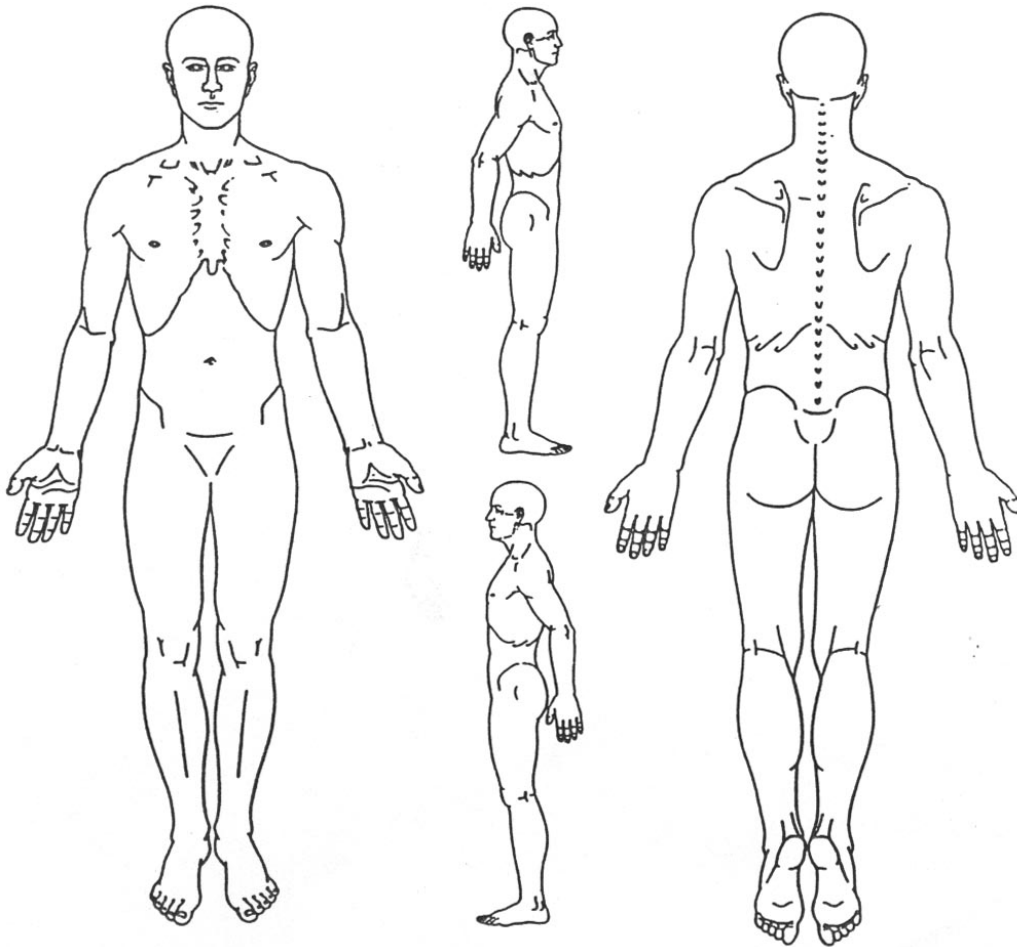
Name \_\_\_\_\_ Date \_\_\_\_\_

Describe the conditions that are bothering you the most today:

1. _____	2. _____
3. _____	4. _____
5. _____	6. _____
7. _____	8. _____

On a 0-100 scale with 0 being no symptoms and 100 being the worst pain imaginable, please write the numbers in the box to the right (corresponding to the numbers above) indicating the level of symptoms (pain, fatigue, burning, indigestion, etc) for the conditions listed above.	1. _____	5. _____
	2. _____	6. _____
	3. _____	7. _____
	4. _____	8. _____

On the body diagrams below, please mark the areas of all your symptoms. Please note which symptoms are achy, burning, numb, stabbing, pounding, tingling, pins and needles, congested, etc. (Placing the appropriate condition number noted above on the diagram below may help the doctor isolate the problem area better.)



Signature _____	Date: _____
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