

DYNAMIC HEALTH INSTITUTE

PAIN – INJURY DISABILITY INDEX

Name _____ Today's Date / / Score _____ [50]

Type of Injury / Condition: _____

This questionnaire is designed to help us better understand how your pain/injury/condition affects your ability to manage everyday life activities. Please mark in each section the ONE box that applies to you. Although you may consider that two of the statements in any one section relate to you – please mark the box that MOST CLOSELY describes your present day situation.

Section 1 – Pain Intensity	Section 6 – Concentration
<input type="checkbox"/> I have no pain at the moment.	<input type="checkbox"/> I can concentrate fully without difficulty.
<input type="checkbox"/> The pain is very mild at the moment.	<input type="checkbox"/> I can concentrate fully with slight difficulty.
<input type="checkbox"/> The pain is moderate at the moment.	<input type="checkbox"/> I have a fair degree of difficulty concentrating.
<input type="checkbox"/> The pain is fairly severe at the moment.	<input type="checkbox"/> I have a lot of difficulty concentrating.
<input type="checkbox"/> The pain is very severe at the moment.	<input type="checkbox"/> I have a great deal of difficulty concentrating.
<input type="checkbox"/> The pain is the worst imaginable at the moment.	<input type="checkbox"/> I can't concentrate at all.
Section 2 – Personal Care	Section 7 – Sleeping
<input type="checkbox"/> I can look after myself normally without causing extra pain.	<input type="checkbox"/> I have no trouble sleeping.
<input type="checkbox"/> I can look after myself normally, but it causes extra pain.	<input type="checkbox"/> My sleep is slightly disturbed for less than 1 hour.
<input type="checkbox"/> It is painful to look after myself and I am slow and careful.	<input type="checkbox"/> My sleep is mildly disturbed for up to 1-2 hours.
<input type="checkbox"/> I need some help but manage most of my personal care.	<input type="checkbox"/> My sleep is moderately disturbed for up to 2-3 hours.
<input type="checkbox"/> I need help every day in most aspects of self-care.	<input type="checkbox"/> My sleep is greatly disturbed for up to 3-5 hours.
<input type="checkbox"/> I do not get dressed. I wash with difficulty and stay in bed.	<input type="checkbox"/> My sleep is completely disturbed for up to 5-7 hours.
Section 3 – Lifting	Section 8 – Driving
<input type="checkbox"/> I can lift heavy weights without causing extra pain.	<input type="checkbox"/> I can drive my car without pain.
<input type="checkbox"/> I can lift heavy weights but it gives me extra pain.	<input type="checkbox"/> I can drive as long as I want with slight pain.
<input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, i.e. On a table	<input type="checkbox"/> I can drive as long as I want because with moderate pain.
<input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.	<input type="checkbox"/> I can't drive as long as I want because of severe pain.
<input type="checkbox"/> I can lift only very light weights.	<input type="checkbox"/> I can hardly drive at all because of severe pain.
<input type="checkbox"/> I cannot lift or carry anything at all.	<input type="checkbox"/> I can't drive my car at all because of pain.
Section 4 – Work	Section 9 – Reading
<input type="checkbox"/> I can do as much work as I want.	<input type="checkbox"/> I can read as much as I want with no pain.
<input type="checkbox"/> I can only do my usual work – no more.	<input type="checkbox"/> I can read as much as I want with slight pain.
<input type="checkbox"/> I can do most of my usual work, but no more.	<input type="checkbox"/> I can read as much as I want because of moderate pain.
<input type="checkbox"/> I can't do my usual work.	<input type="checkbox"/> I can't read as much as I want because of moderate pain.
<input type="checkbox"/> I can hardly do any work at all.	<input type="checkbox"/> I can't read as much as I want because of severe pain.
<input type="checkbox"/> I can't do any work at all.	<input type="checkbox"/> I can't read at all.
Section 5 – Headaches	Section 10 – Recreation
<input type="checkbox"/> I have no headaches at all.	<input type="checkbox"/> I have no pain during all recreational activities.
<input type="checkbox"/> I have slight headaches that come infrequently.	<input type="checkbox"/> I have some pain with all recreational activities.
<input type="checkbox"/> I have moderate headaches that come infrequently.	<input type="checkbox"/> I have some pain with a few recreational activities.
<input type="checkbox"/> I have moderate headaches that come frequently.	<input type="checkbox"/> I have pain with most recreational activities.
<input type="checkbox"/> I have severe headaches that come frequently.	<input type="checkbox"/> I can hardly do recreational activities due to pain.
<input type="checkbox"/> I have headaches almost all the time.	<input type="checkbox"/> I can't do any recreational activities due to pain.