

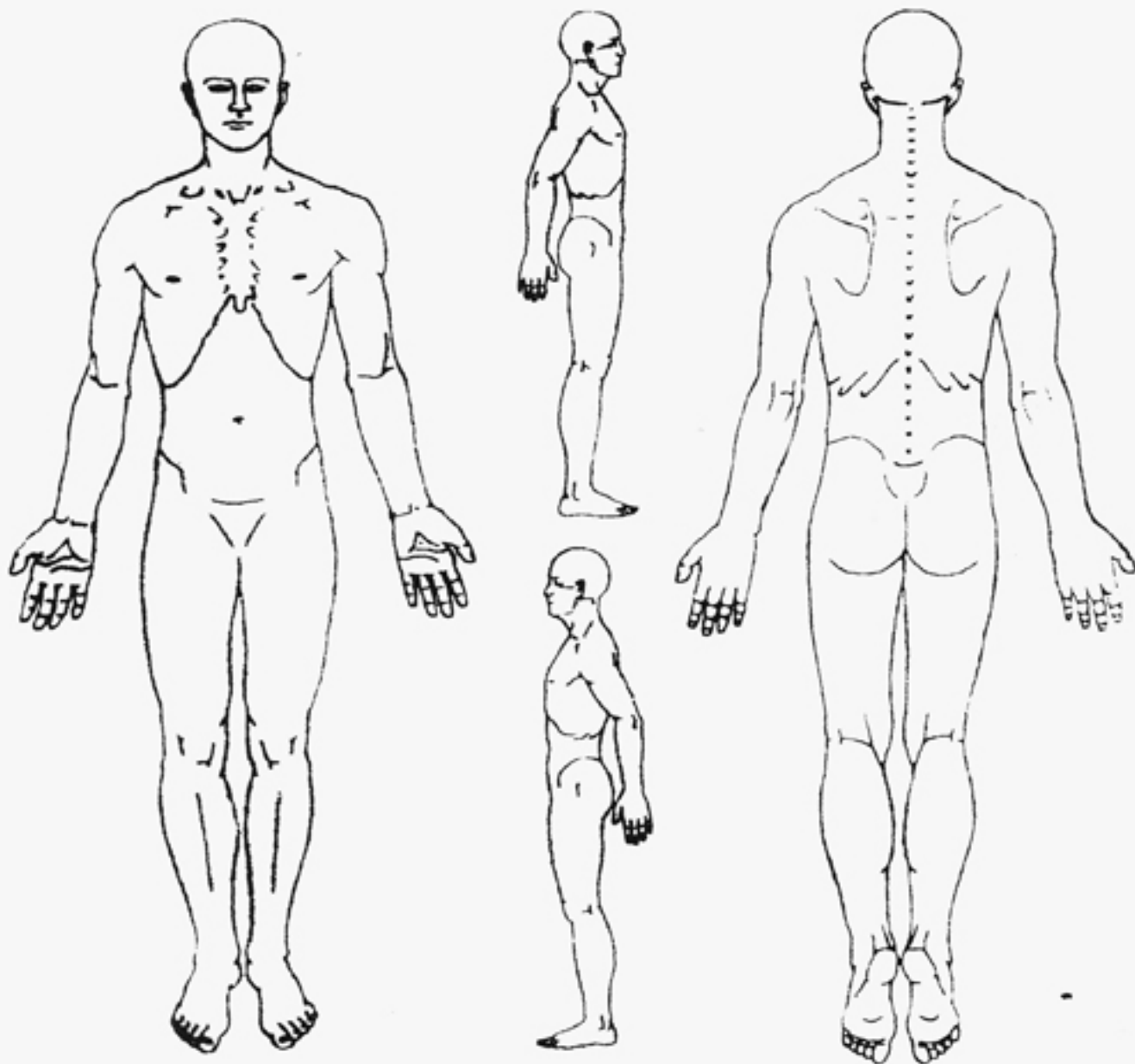
## GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

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**

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



0      1      2      3      4      5      6      7      8      9      10  
No Pain    Mild Pain    Moderate Pain    Severe Pain    Most Pain Possible

Please circle the level of pain that you are experiencing at this time.