Quality of Life/Functional Study

(Evaluate q 6 month)

DOCTORS© PAIN CLINIC

Patient name _____ Date _____

In the past month have you done any of the following?

(Please check)	Yes	No
Worked?		
Participated in volunteer activities?		
Participated in a hobby?		
Spent time feeding or caring for a pet?		
Preformed childcare/family care/eldercare activities?		
Talked with family or friends?		
Took a walk or exercised?		
Spent time on line on the computer?		
Wrote a letter or email?		
Took time for yourself?		
Visited with friends and or relatives?		
Attended church or social function?		
Shopped?		
Performed other outside activities?		
Read (newspaper, book magazine, bible, internet)?		
Played cards/board games/video games?		
Worked crossword puzzles/jigsaw puzzles/sudoku etc.?		
Made something?		
Worked outdoors in a garden/yard/care for plants?		
Watched a movie?		
Prepared meals?		
Baked?		
Cleaned house/laundry?		
Completed household repairs?		
Listen to music?		
For staff use. Total YES answers =	**Total**	**Total**

Legend: 0-5 poor 6-10 fair 11-15 good 16-20 very good 21-25 excellent

Patient signature _____

Staff signature _____

Quality of Life

Patient name _____ Date _____

(NON APPLICABLE FOR INITIAL VISIT)
Since starting the Pain Program what improvements have you experienced?

(Check all that apply)	Yes	No	Sometimes
Less pain			
More movement			
Less depression			
Able to work			
Fewer emergency room visits			
Able to leave the house more			
Do you believe your pain level has improved since you started the pain program?			
Do you believe that your quality of life has improved since you started the pain program?			
Do you believe your pain is under enough control to withdraw from your medication(s)?			

Patient signature _____

Staff signature _____

10/09