

FIBROMYALGIA CENTERS OF AMERICA

Dr. Robert J. Scranton

FIBROMYALGIA IMPACT QUESTIONNAIRE (FIQ)

Name _____ Age _____ M _____ F _____

Address _____

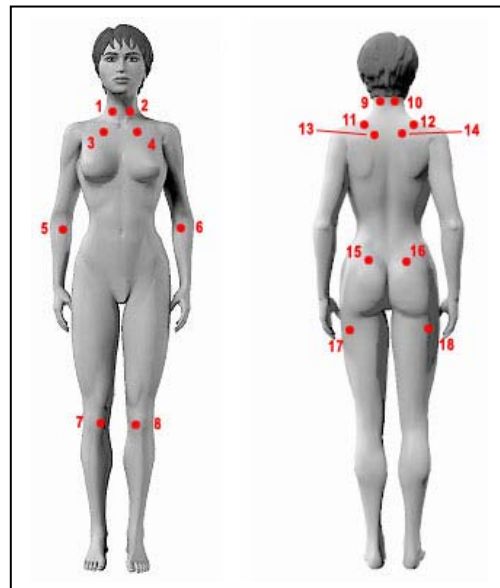
City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Occupation _____ Chiropractor _____

Please check any symptoms that you *presently* have or *occasionally* suffer from:

- Aching
- Tender Points
- Recurring Headaches
- Neck Pain
- Facial Pain
- Chronic Fatigue
- Anxiety
- Bowel or Urinary Dysfunction
- TMJ (Jaw Pain)
- Decreased Coordination
- Sleep Disturbances



Trigger Points:

1. Do you have 11 of the 18 trigger points in the picture above?

Yes _____ No _____

2. Number of Trigger Points Found _____

3. Would You like to get rid of this condition?

Yes _____ No _____

Directions: For questions 1 through 11, please circle the number that best describes how you did overall for the *past week*. If you don't normally do something that is asked, cross the question out.

Always Mostly Occasional Never

Were you able to:

<i>Do shopping?</i>	0	1	2	3
<i>Do laundry with a washer and dryer?</i>	0	1	2	3
<i>Prepare meals?</i>	0	1	2	3
<i>Wash dishes/cooking utensils by hand?.....</i>	0	1	2	3
<i>Vacuum a rug?.....</i>	0	1	2	3
<i>Make beds?</i>	0	1	2	3
<i>Walk several blocks?</i>	0	1	2	3
<i>Visit friends or relatives?</i>	0	1	2	3
<i>Do yard work?.....</i>	0	1	2	3
<i>Drive a car?</i>	0	1	2	3
<i>Climb stairs?</i>	0	1	2	3

12. *Of the 7 days in the past week, how many days did you feel good?*

0 1 2 3 4 5 6 7

13. *How many days last week did you miss work, including housework, because of Fibromyalgia?*

0 1 2 3 4 5 6 7

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1 Delighted

2. Mostly Satisfied

3. Mixed feelings

4. Mostly Dissatisfied

5. Unhappy

6. Terrible