

Tennessee Bureau of Workers’ Compensation

MEDICAL IMPAIRMENT RATING REGISTRY

220 French Landing Drive

Nashville, Tennessee 37243-0651

(615) 253-5616; Fax: 615-253-5263

**Medical Impairment Rating (MIR) Report**

**AMA Guides, 6th Edition**

For dates of injury on or after January 1, 2008; please key all responses.

Please send completed forms via secure email to jay.blaidsdell@tn.gov or fax at 615-253-5263.

**PATIENT INFORMATION:**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| Claimant Name:  |  |
|  |  |  |  |
| Address:  |  |
|  |  |  |  |
| City:  |  | State:  |  |
|  |  |  |  |
| Phone: |  | ZIP: |  |  |
|  |  |  |  |
| State File:  |  | MIR Case: |  |  |
|  |  |  |  |
| Social Security:  |  | Date of Birth:  |  |
|  |  |  |  |
| Date of Injury:  |  | Date of MIR Evaluation:  |  |
|  |  |  |  |

**MIR PHYSICIAN INFORMATION:**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| Physician Name: |  |
|  |  |  |  |
| Address: |  |
|  |  | State:  |  |
| City: |  |  |  |
|  |  | ZIP: |  |
| Phone: |  |  |  |
|  |  | Fax: |  |
| Location of evaluation (if different than above): |  |
|  |

|  |
| --- |
| **LIST THE FINAL WHOLE PERSON IMPAIRMENT:** |
|  |  |  |  |  |
| In NUMBERS: |  | % WPI |  |  |
|  |  |  |  |  |
| AND |  |  |  |  |
|  |  |  |  |  |
| In WORDS: |  | Whole Person Impairment. |

[This is the FINAL rating legally presumed to be the correct impairment rating.]

**PHYSICIAN CERTIFICATION AND QUALIFICATIONS:**

“It is my opinion, both within and to a reasonable degree of medical certainty that, based upon all information available to me at the time of the MIR impairment evaluation and by utilizing the***AMA Guides 6th Edition*** with its Errata, or other appropriate method as noted that the claimant has the permanent impairment so described in this report. I certify that the opinion furnished is my own, that this document accurately reflects my opinion, and that I am aware that my signature attests to its truthfulness. I further certify that my statement of qualifications to serve on the MIR Registry is both current and completely accurate.”

Signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Dated:

Printed full name of physician

**Step One: Clinical Evaluation**

**PATIENT HISTORY:**

INTRODUCTION AND OVERVIEW (EXAMINEE’S brief description of the injury/illness. EXAMINEE’S description of prior treatment and the treatment outcome, the time periods examinee was unable to work, CURRENT SYMTPOMS as described by the EXAMINEE, current medications, AND CURRENT ADL limitations. Note Record Review is to be documented in the sections that follow Physical Examination.)

|  |
| --- |
|  |

**PHYSICAL EXAMINATION:**

(Including height and weight)

|  |
| --- |
|  |

**CLAIMANT’S CHRONOLOGICAL MEDICAL HISTORY**

**FOR THIS INJURY**

|  |  |  |
| --- | --- | --- |
| **Name and address** of all treatment providers: | **Date** treatment received: | **Diagnosis** of the injury or illness and part of the body affected: |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**INSERT NARRATIVE RECORD REVIEW HERE, IF NECESSARY:**

**MEDICAL RECORD REVIEW:**

In the space below, **check** the applicable blocks next to any test results which you reviewed and relied upon to base your medical assessments or conclusions. Be sure to **indicate** whether you review imaging reports, OR, both the imaging reports and the actual images. Be sure to show the date of each test and summarize results. Please **attach** copy(ies) of the report(s).

 **DATE(S) PERFORMED SUMMARY OF RESULTS**

Please note whether it was the actual images reviewed or if the paper report was reviewed.

**[** **] X-RAY**

**# Reviewed**

|  |
| --- |
|  |

**[** **] X-RAY Reports**

**# Reviewed**

|  |
| --- |
|  |

**[** **] EMG/NCS**

**# Reviewed**

|  |
| --- |
|  |

**[** **]** If radiculopathy exists, state abnormal findings that are consistent with radiculopathy:

|  |
| --- |
|       |

**[** **]** If a peripheral nerve entrapment exists, state any abnormal findings, and state whether they meet *Guides* criteria for conduction delay, conduction block, or axon loss:

|  |
| --- |
|  |

**[** **]** If an acute traumatic peripheral nerve injury occurred, state findings that are consistent with permanent nerve dysfunction:

|  |
| --- |
|  |

**[** **] CT SCAN**

**# Reviewed**

|  |
| --- |
|  |

**[** **] MYELOGRAM**

**# Reviewed**

|  |
| --- |
|  |

**[** **] MRI**

**# Reviewed**

|  |
| --- |
|  |

**[** **] OTHERS (Describe)**

**# Reviewed**

|  |
| --- |
|  |

**SURGICAL PROCEDURES:**

Please **list** all operative procedures performed in chronological order with the operation title noted. **Attach** copy (ies) of report(s) if surgery was performed. **List** operative findings:

|  |
| --- |
|  |

**Step Two: Analysis of the Findings**

1. Does the claimant have a permanent impairment?YESNO
2. Has the claimant reached maximum medical improvement (MMI)? YES NO

If YES, date MMI was reachedIf NO, state why the examinee is NOT atMMI, and what will be needed for the examinee to be at MMI. PLEASE RATE THE IMPAIRMENT REGARDLESS. [Note: If you feel the patient is not at MMI because an additional treatment is required, you MUST document that the patient wants the additional treatment performed.]

|  |
| --- |
|  |

1. Do the *AMA Guides, 6TH EDITION* with its ERRATA adequately assess the medical impairment rating of the claimant? YES  NO  If NO, state why they do not.

|  |
| --- |
|  |

1. List ALL diagnoses for which there is a ratable permanent impairment causally related to the work injury or exposure in question:

|  |  |
| --- | --- |
| **1.** |  |
| **2.** |  |
| **3.** |  |
| **4.** |  |
| **5.** |  |
| **6.** |  |

**5.** Are there diagnoses which the *AMA* *Guides, 6th Edition* does not include in impairment tables or for which the *Guides* does not provide a methodology, so that rating “by analogy” to a condition that is covered in the *Guides* must be used for impairment rating? (Pages 385, 495, 559, etc.) YESNO

If YES, please list the diagnosis in question and express an impairment percentage that you think is appropriate, explain the analogy utilized to determine it, and explain in detail how you arrived at the percentage of impairment chosen. Calculated total whole person impairment:%.

|  |
| --- |
|  |

**Step Three: Discussion**

1. Using the *AMA’s Physicians Guide to the Evaluation of Permanent Impairment,* **6th Edition**, please translate each of the claimant’s diagnoses as documented above to a percentage of impairment. If there are more than 6 ratable diagnoses, photocopy this page and submit this table for each additional diagnosis.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Diagnosis 1 | Diagnosis 2 | Diagnosis 3 |
| Diagnosis |  |  |  |
| Body part/system |  |  |  |
| Chapter # |  |  |  |
| Table #/page # |  |  |  |
| Key factor |  |  |  |
| Diagnosis line used |  |  |  |
| Class  |  |  |  |
| Grade Modifier FH |  |  |  |
| Grade Modifier PE |  |  |  |
| Grade Modifier CS |  |  |  |
| BOTC (if applicable) |  |  |  |
| Final Class and Grade Used |  |  |  |
| Regional impairment |  |  |  |
| Whole person impairment |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Diagnosis 4 | Diagnosis 5 | Diagnosis 6 |
| Diagnosis |  |  |  |
| Body part/system |  |  |  |
| Chapter # |  |  |  |
| Table #/page # |  |  |  |
| Key factor |  |  |  |
| Diagnosis line used |  |  |  |
| Class  |  |  |  |
| Grade Modifier FH |  |  |  |
| Grade Modifier PE |  |  |  |
| Grade Modifier CS |  |  |  |
| BOTC (if applicable) |  |  |  |
| Final Class and Grade Used |  |  |  |
| Regional impairment |  |  |  |
| Whole person impairment |  |  |  |

**Diagnosis 1.** Please restate diagnosis:

|  |
| --- |
|  |

Criteria that support this diagnosis as present:

|  |
| --- |
|  |

|  |  |  |
| --- | --- | --- |
| Class: |  | Criteria that support choice of Class for this diagnosis: |
|  |  |  |
| Functional History, Grade Modifier:  |  | Criteria that support choice of this Grade Modifier, or reason this Modifier is not used: |
|  |  |  |
| Physical Exam, Grade Modifier:  |  | Criteria that support choice of this Grade Modifier, or reason this Modifier is not used: |
|  |  |  |
| Clinical Studies, Grade Modifier:  |  | Criteria that support choice of this Grade Modifier, or reason this Modifier is not used: |
|  |  |  |
| Burden of Treatment Compliance Grade Modifier (if chapter nine orten was used):  |  | Criteria that support choice of this Grade Modifier, or reason this Modifier is not used: |

NET ADJUSTMENT FORMULA, IF APPLICABLE:

 (Functional History Grade Modifier ) - (Class) = (Adjustment)

 + (Physical Exam Grade Modifier ) - (Class) = (Adjustment)

 + (Clinical Studies Grade Modifier ) - (Class) = (Adjustment)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 TOTAL NET ADJUSTMENT =

 FINAL GRADE (A, B, C, D, or E) =

**Diagnosis 2.** Please restate diagnosis:

|  |
| --- |
|  |

Criteria that support this diagnosis as present:

|  |
| --- |
|  |

|  |  |  |
| --- | --- | --- |
| Class: |  | Criteria that support choice of Class for this diagnosis:  |
|  |  |  |
| Functional History, Grade Modifier:  |  | Criteria that support choice of this Grade Modifier, or reason this Modifier is not used: |
|  |  |  |
| Physical Exam, Grade Modifier:  |  | Criteria that support choice of this Grade Modifier, or reason this Modifier is not used: |
|  |  |  |
| Clinical Studies, Grade Modifier:  |  | Criteria that support choice of this Grade Modifier, or reason this Modifier is not used: |
|  |  |  |
| Burden of Treatment Compliance Grade Modifier (if chapter nine orten was used):  |  | Criteria that support choice of this Grade Modifier, or reason this Modifier is not used:  |

NET ADJUSTMENT FORMULA, IF APPLICABLE:

 (Functional History Grade Modifier ) - (Class) = (Adjustment)

 + (Physical Exam Grade Modifier ) - (Class) = (Adjustment)

 + (Clinical Studies Grade Modifier ) - (Class) = (Adjustment)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 TOTAL NET ADJUSTMENT =

 FINAL GRADE (A, B, C, D, or E) =

 **Please submit this page for each additional ratable diagnosis.**

**Diagnosis** **.** Please restate diagnosis:

|  |
| --- |
|       |

Criteria that support this diagnosis as present:

|  |
| --- |
|  |

|  |  |  |
| --- | --- | --- |
| Class: |  | Criteria that support choice of Class for this diagnosis: |
|  |  |  |
| Functional History, Grade Modifier:  |  | Criteria that support choice of this Grade Modifier, or reason this Modifier is not used: |
|  |  |  |
| Physical Exam, Grade Modifier:  |  | Criteria that support choice of this Grade Modifier, or reason this Modifier is not used: |
|  |  |  |
| Clinical Studies, Grade Modifier:  |  | Criteria that support choice of this Grade Modifier, or reason this Modifier is not used: |
|  |  |  |
| Burden of Treatment Compliance Grade Modifier (if chapter nine orten was used):  |  | Criteria that support choice of this Grade Modifier, or reason this Modifier is not used: |

NET ADJUSTMENT FORMULA, IF APPLICABLE:

 (Functional History Grade Modifier ) - (Class) = (Adjustment)

 + (Physical Exam Grade Modifier ) - (Class) = (Adjustment)

 + (Clinical Studies Grade Modifier ) - (Class) = (Adjustment)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 TOTAL NET ADJUSTMENT =

 FINAL GRADE (A, B, C, D, or E) =

*Use this table for any* ***Central Nervous System injury, condition, or diagnosis*** *to be rated:*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Chapter 13Central Nervous SystemDiagnosis or Condition | Table Number/Page Number | Rationale for Impairment % Chosen | % Impairment of theScheduled Member | %Impairmentof theWhole PersonIf appropriate |
| a.  |  |  |  |  |
| b.   |  |   |  |  |
| c.   |  |    |  |  |

*Use this section and table for any* ***mental or behavioral disorder or diagnosis*** *to be rated:*

Are you a Psychiatrist? YESNO If YES, continue. If NO, do not complete this section.

**Diagnosis:**

Axis I: [Please remember—this is the only diagnosis that potentially could be ratable]

|  |
| --- |
|  |

Axis II:

|  |
| --- |
|  |

Axis III:

|  |
| --- |
|  |

Axis IV:

|  |
| --- |
|  |

Axis V: (GAF)

|  |
| --- |
|  |

|  |  |
| --- | --- |
| BPRS impairment score |  |
| GAF impairment score |  |
| PIRS impairment score |  |
| Median or middle value of these 3 – Impairment (WPI) |  |
| Subtract impairment for pre-existing mental disorder or borderline intellectual function |  |
| FINAL IMPAIRMENT RATING FROM CHAPTER 14 |  |

Submit photocopy of Table 14-8 of the *Guides* with score for each BPRS item circled. Narrative report *must* contain documentation for each BPRS Symptom Construct. Your narrative report *must* also contain documentation for choice of GAF Scale and *must* contain documentation for choice of each score from Tables 14-12 through 14-16.

|  |
| --- |
|  |

*Use this table if there are* ***multiple ratable impairments.***

List the mathematically highest impairment first, then in order of decreasing numerical impairment.

|  |  |
| --- | --- |
| Diagnoses | Whole Person Impairment |
| **#1** |  |
| **#2** |  |
| **#3** |  |
| **#4** |  |
| **#5** |  |
| **#6** |  |
| Final Whole Person Impairment from Combined Values  |  |

Is there a prior, work-related medical impairment rating that should be considered for subtraction from the impairment(s) described above?  **YES   NO** If YES, state the prior medical impairment rating and in the following section, “COMMENTS ON IMPAIRMENT RATING,” calculate the final rating both WITH AND WITHOUT subtraction of this pre-existing, work-related impairment rating.

|  |
| --- |
|  |

**COMMENTS ON IMPAIRMENT RATING:**

(If applicable, please include a discussion on subtracting prior, work-related, impairment ratings. Please discuss 1. any possible inconsistencies, 2. the rationale of the impairment rating, and 3. the RATINGS ASSIGNED BY OTHER PHYSICIANS, and WHY this rating is correct and the other ratings, if different, are not correct.)

|  |
| --- |
|  |

If a QuickDASH Form, AAOS Lower Limb Outcome Form, a Pain Disability Questionnaire Form or any other questionnaire was completed by the examinee, please include a copy, along with your [*curriculum vitae*](http://www.google.com/search?rlz=1T4GGLL_enUS379US379&safe=active&hl=en&q=curriculum%20vitae&spell=1&sa=X)*,* in your report. Please complete and return, before due date, with all required attachments to:

Please send completed forms via secure email to **jay.blaidsdell@tn.gov**
or fax at 615-253-5263.

**Tennessee Bureau of Workers’ Compensation**

*ATTN: Jay Blaisdell, MIR Program Coordinator*

*220 French Landing Drive*

*Nashville, Tennessee 37243-0661*

**QuickDASH: Disabilities of the Arm, Shoulder and Hand**

Instructions: This questionnaire asks about your symptoms as well as your ability to perform certain activities. Please answer *every question*, based on your condition in the last week, by circling the appropriate number. If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate.

(1 is not difficult, not limited, or none; 2 is mild difficulty, slightly limited, or mild; 3 is moderate difficulty, moderately limited, or moderate; 4 is severe difficulty, very limited, or severe; and 5 is unable, extremely, or extreme.)

**QuickDASH DISABILITY/SYMPTOM SCORE =([Sum of n responses/n] -1) x 25**

**where n is equal to the number of completed responses.**

**A QuickDASH score may not be calculated if there is greater than 1 missing item.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  **1. Open a tight or new jar.** | **1****[ ]**  | **2****[ ]**  | **3****[ ]**  | **4****[ ]**  | **5****[ ]**  |
|  **2. Do heavy household chores (e.g., wash walls, floors).** | **1****[ ]**  | **2[ ]**  | **3[ ]**  | **4[ ]**  | **5[ ]**  |
|  **3. Carry a shopping bag or briefcase.** | **1[ ]**  | **2[ ]**  | **3[ ]**  | **4[ ]**  | **5[ ]**  |
|  **4. Wash your back.** | **1[ ]**  | **2[ ]**  | **3[ ]**  | **4[ ]**  | **5[ ]**  |
|  **5. Use a knife to cut food.** | **1[ ]**  | **2[ ]**  | **3[ ]**  | **4[ ]**  | **5[ ]**  |
|  **6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).** | **1[ ]**  | **2[ ]**  | **3[ ]**  | **4[ ]**  | **5[ ]**  |
|  **7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or group?** | **1[ ]**  | **2[ ]**  | **3[ ]**  | **4[ ]**  | **5[ ]**  |
|  **8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?** | **1[ ]**  | **2[ ]**  | **3[ ]**  | **4[ ]**  | **5[ ]**  |
|  **9. Arm, shoulder or hand pain.** | **1[ ]**  | **2[ ]**  | **3[ ]**  | **4[ ]**  | **5[ ]**  |
| **10. Tingling (pins and needles) in your arm, shoulder or hand.** | **1[ ]**  | **2[ ]**  | **3[ ]**  | **4[ ]**  | **5[ ]**  |
| **11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?** | **1[ ]**  | **2[ ]**  | **3[ ]**  | **4[ ]**  | **5[ ]**  |

**Pain Disability Questionnaire**

Instructions: These questions ask your view about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. **Does your pain interfere with your normal work inside and outside the home?**

Work normally Unable to work at all

 0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

 [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

1. **Does your pain interfere with personal care (such as washing, dressing, etc.)?**

Take care of myself completely Need help with all my personal care

 0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

 [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

1. **Does your pain interfere with your traveling?**

Travel anywhere I like Only travel to see doctors

 0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

 [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

1. **Does your pain affect your ability to sit or stand?**

No problems Cannot sit/stand at all

 0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

 [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

1. **Does your pain affect your ability to lift overhead, grasp objects, or reach for things?**

No problems Cannot do at all

 0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

 [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

1. **Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?**

No problems Cannot do at all

 0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

 [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

1. **Does your pain affect your ability to walk or run?**

No problems Cannot walk/run at all

 0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

 [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

1. **Has your income declined since your pain began?**

No decline Lost all income

 0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

 [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

1. **Do you have to take pain medication every day to control your pain?**

No medication needed On pain medication throughout the day

 0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

 [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

1. **Does your pain force you to see doctors much more often than before your pain began?**

Never see doctors See doctors regularly

 0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

 [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

1. **Does your pain interfere with your ability to see the people who are important to you as much as you would like?**

No problem Never see them

 0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

 [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

1. **Does your pain interfere with recreational activities and hobbies that are important to you?**

No interference Total interference

 0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

 [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

1. **Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?**

Never need help Need help all the time

 0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

 [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

1. **Do you now feel more depressed, tense, or anxious than before your pain began?**

No depression/tension Severe depression/tension

 0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

 [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

1. **Are there emotional problems caused by your pain that interfere with your family, social and or work activities?**

No problems Severe problems

 0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

 [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]