Fibromyalgia and Myofascial Pain Syndrome Functional Questionnaire

To: _____

Re: _____ (Name of Patient)

_____ (Social Security Number)

Please answer the following:

1. Nature, frequency, and length of contact with your patient:

   _____

   _____

2. Does your patient meet the American Rheumatological clinical testing criteria for Fibromyalgia? ____ Yes ____ No

3. List any other diagnosed impairments or coexisting conditions:

   _____

4. Prognosis: _____

5. Have your patient's impairments lasted or can they be expected to last at least 12 months?

   ____ Yes ____ No

6. Identify the clinical findings, the laboratory and test results that show your patient's medical impairments: _____

7. Identify all of your patient's symptoms:

- ____ Multiple tender points
- ____ Nonrestorative sleep
- ____ Chronic fatigue
- ____ Morning stiffness
- ____ Subjective swelling
- ____ Irritable Bowel Syndrome
- ____ Depression
- ____ Mitral valve prolapse
- ____ Hypothyroidism
- ____ Vestibular dysfunction
- ____ Lack of coordination
- ____ Cognitive Impairment
- ____ Multiple trigger points
- ____ Difficulty communicating
- ____ Balance problems
- ____ Shortness of breath
- ____ Stress incontinence
- ____ Mood swings
- ____ Sensitivity to cold, heat, humidity, noise, light
- ____ Numbness and tingling
- ____ Sicca symptoms
- ____ Raynaud's phenomenon
- ____ Dysmenorrhea
- ____ Anxiety
- ____ Panic attacks
- ____ Frequent severe headaches
- ____ Female Urethral Syndrome
- ____ Premenstrual Syndrome
- ____ Carpal Tunnel Syndrome
- ____ Chronic Fatigue Syndrome
- ____ TMJ Dysfunction
- ____ Myofascial Pain Syndrome
- ____ Dizziness
- ____ Headaches/migraines
- ____ Multiple chemical sensitivity
- ____ Free-floating anxiety
- ____ Unaccountable irritability
- ____ Problems climbing or going down stairs

in nature of cognitive impairment(s) by circling those that apply: trouble concentrating, ity to get known words out, visual perception problems, short-term memory impair- fugue states (staring into space before brain can function), inability to deal with multi- ensory stimuli, difficulty multitasking, other:

your patient has pain:

entify the location of pain, including, where appropriate, an indication of affected eas:

_____ Lumbosacral spine _____ Thoracic spine

_____ Cervical spine _____ Chest

	Right	Left	Bilateral
_____ Shoulders	_____	_____	_____
_____ Arms	_____	_____	_____
_____ Hands/fingers	_____	_____	_____
_____ Hips	_____	_____	_____
_____ Legs	_____	_____	_____
_____ Knees/ankles/feet	_____	_____	_____

escribe the nature, frequency, and severity of your patient's pain:

entify any factors that precipitate pain:

_____ Changing weather _____ Fatigue _____ Movement/overuse

_____ Stress _____ Hormonal changes _____ Cold _____ Heat

_____ Humidity _____ Static position _____ Allergy _____ Other

your patient a malingerer? ____ Yes ____ No

10. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? ____ Yes ____ No

11. Are your patient's physical impairments plus any emotional impairments reasonably consistent with symptoms and functional limitations described in this evaluation?

____ Yes ____ No

12. How often is your patient's experience of pain sufficiently severe to interfere with attention and concentration?

____ Never ____ Seldom ____ Often ____ Frequently ____ Constantly

13. To what degree is your patient limited in the ability to deal with work stress?

____ No limitation ____ Slight limitation ____ Moderate limitation

____ Marked limitation ____ Severe limitation

14. Identify the side effects of any medication which may have implications for working, e.g., dizziness, drowsiness, stomach upset, etc:

_____

_____

15. In view of your patient's impairments, estimate your patient's functional limitations if your patient were placed in a competitive work situation:

a) How many city blocks can your patient walk without rest or severe pain? _____

Comment _____

b) Please circle the hours and/or minutes that your patient can continually sit and stand at one time without experiencing delayed onset symptoms:

Sit	Stand/walk		Sit	Stand/walk	
____	____	Less than 2 hours	____	____	About 4 hours
____	____	About 2 hours	____	____	At least 6 hours

c) Does your patient need to include periods of walking during an 8 hour day?

____ Yes ____ No ____ Cannot work an 8 hr day

d) Does your patient need a job that permits shifting positions at-will from sitting, standing, or walking? ____ Yes ____ No

e) Will your patient sometimes need to lie down at unpredictable intervals during a work shift? ____ Yes ____ No

f) With prolonged sitting, should your patient's legs be elevated?

____ Yes ____ No ____ Cannot tolerate prolonged sitting

g) *While engaged in occasional standing/walking, must your patient use a cane or other assistive device?* ____ *Yes* ____ *No*

h) How many pounds can your patient carry in a competitive work situation without suffering delayed onset symptoms?

	Never	Occasionally	Frequently
____ Less than 10 lbs	_____	_____	_____
____ 10 lbs	_____	_____	_____
____ 20 lbs	_____	_____	_____
____ 50 lbs	_____	_____	_____

In an average workday, "occasionally" means less than one-third of a workday; "frequently" means between one-third to two-thirds of the workday.

i) Does your patient have any significant limitations in reaching, handling, or fingering?

____ Yes ____ No

If yes, please indicate the percentage of time during a workday on a competitive job that your patient can use hands/fingers/arms for the following repetitive activities:

Hands (grasp, turn, twist objects)	Right_____%	Left_____%
Fingers (fine manipulation)	Right_____%	Left_____%
Arms (reaching, including overhead)	Right_____%	Left_____%

j) Does your patient have difficulties with fine motor control? ____ Yes ____ No

16. On the average, how often do you anticipate that your patient's impairments and treatments would cause the patient to be absent from work?

____ Never ____ Less than once a month

____ About twice a month ____ About three times a month

____ About once a month ____ More than three times a month

17. Please describe any other limitations that would affect this patient's ability to work at a regular job on a sustained basis:

_____

_____

_____

_____

18. Does your patient have (Y or N):

____ nausea ____ cramps ____ buckling ankles ____ buckling knees

____ leg cramps ____ sciatica ____ muscle twitching ____ anxiety

____ lack of endurance ____ handwriting difficulties?

Date: _____ Signed: _____

Print/type name: _____

Address: _____