Fibromyalgia Impact Questionnaire

Name_____ Date_____

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.

Were you able to:	Always	Most	Occasionally	Never
1. Do Shopping?	0	1	2	3
2. Do laundry with a washer and dryer?	0	1	2	3
3. Prepare meals?	0	1	2	3
4. Wash dishes/cooking utensils by hand?	0	1	2	3
5. Vacuum a rug?	0	1	2	3
6. Make beds?	0	1	2	3
7. Walk several blocks?	0	1	2	3
8. Visit friends or relatives?	0	1	2	3
9. Do yard work?	0	1	2	3
10. Drive a car?	0	1	2	3
11. Climb stairs?	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

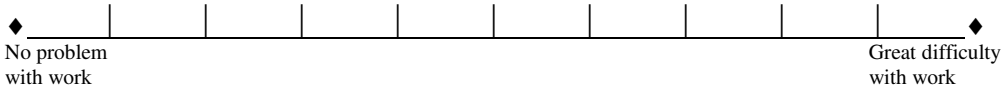
13. How many days last week did you miss work, including housework, because of fibromyalgia?

0 1 2 3 4 5 6 7

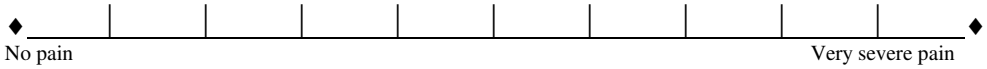
PLEASE TURN PAGE OVER AND COMPLETE SIDE 2.

Directions: For the remaining items, mark the point on the line that best indicates how you felt **overall** for the past week?

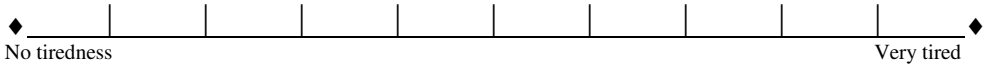
14. When you worked, how much did pain or other symptoms of your fibromyalgia interfere with your ability to do your work, including housework?



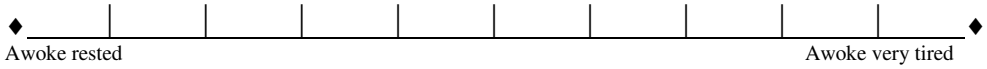
15. How bad has your pain been?



16. How tired have you been?

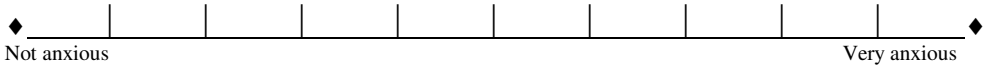


17. How have you felt when you get up in the morning?



18. How bad has your stiffness been?

19. How nervous or anxious have your felt?



20. How depressed or blue have you felt?