Pain Disability Index

***Required Medicare Form

Name:______________________________

Date:______________________________

Height:______________________________

Weight:______________________________

Vitals:______________________________

This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please click the answers below that best apply:**

Family/Home Responsibilities

Total Disability			Severe			Moderate		Mild		No Disability
10	9	8	7	6	5	4	3	2	1	0

Recreation

Total Disability			Severe			Moderate		Mild		No Disability
10	9	8	7	6	5	4	3	2	1	0

Social Activity

Total Disability			Severe			Moderate		Mild		No Disability
10	9	8	7	6	5	4	3	2	1	0

Occupation

Total Disability			Severe			Moderate		Mild		No Disability
10	9	8	7	6	5	4	3	2	1	0

Sexual Behavior

Total Disability			Severe			Moderate		Mild		No Disability
10	9	8	7	6	5	4	3	2	1	0

Self Care (dressing, grooming, bathing)

Total Disability			Severe			Moderate		Mild		No Disability
10	9	8	7	6	5	4	3	2	1	0

Life Support Activity (eating, sleeping, toileting)

Total Disability			Severe			Moderate		Mild		No Disability
10	9	8	7	6	5	4	3	2	1	0

Please do not complete this section below for your initial visit

This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please click the answers below that best apply:**

1. Please rate your pain level with activity: NO Pain = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN
2. How satisfied are you with the level of care/service provided? **Very Satisfied / Satisfied / Dissatisfied**
3. Rate your progress with functional activities from start of therapy to this point in time. **Excellent / Good / Fair / Poor**
4. At this point in your treatment, have your therapy goals been met? **Completely / Mostly / Partially / Not Met**