Functional Impact Questionnaire

Name: ___________________________________________ Date: __________________

My Symptoms: Please describe your symptoms that brought you here for treatment:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please Read:
We want to measure the impact that the symptoms that brought you here have on your daily activities. Please answer every section. Mark in each section only one box that best applies to the symptoms that brought you here. We realize you may consider that two of the statements in any one section may relate to you, but please just mark the box that most closely describes your problem.

Section 1 – Personal Care Activities (Washing, Dressing, Cooking, etc.)
☐ I can perform all personal care activities without symptoms
☐ I can perform all personal care activities but with symptoms
☐ My symptoms prevents me from performing some of my personal care activities
☐ My symptoms prevents me from performing most of my personal care activities
☐ My symptoms requires I receive assistance with all of my personal care activities
☐ My symptoms prevents me from getting out of bed except to go to the doctor

Section 2 – Lifting Objects
☐ I can lift any object without symptoms
☐ I can lift any object but with symptoms
☐ My symptoms prevents me from lifting heavy objects (bag of groceries)
☐ My symptoms prevents me from lifting moderate objects (gallon of milk)
☐ My symptoms prevents me from lifting light objects (book)
☐ My symptoms prevents me from lifting anything at all

Section 3 – Walking
☐ I can walk as long as I like without symptoms
☐ I can walk as long as I like with symptoms
☐ My symptoms prevents me from walking more than 1 mile
☐ My symptoms prevents me from walking more than ½ mile
☐ My symptoms prevents me from walking around the house
☐ My symptoms prevents me from walking at all.

Section 4 – Sitting
☐ I can sit as long as I like without symptoms
☐ I can sit as long as I like with symptoms
☐ My symptoms prevents me from sitting for more than 1 hour
☐ My symptoms prevents me from sitting for more than 30 minutes
☐ My symptoms prevents me from sitting for more than 10 minutes
☐ My symptoms prevents me from sitting at all

Section 5 – Standing
☐ I can stand as long as I want with no symptoms
☐ I can stand as long as I want with symptoms
☐ My symptoms prevents me from standing longer than 1 hour
☐ My symptoms prevents me from standing longer than 30 minutes
☐ My symptoms prevents me from standing longer than 10 minutes
☐ My symptoms prevents me from standing at all
Section 6 – Sleeping
- I sleep as long as I like without symptoms
- I sleep as long as I like with symptoms
- My symptoms prevents me from sustained sleeping longer than 6 hours
- My symptoms prevents me from sustained sleeping longer than 4 hours
- My symptoms prevents me from sustained sleeping longer than 2 hours
- My symptoms prevents me sleeping at all

Section 7 – Sex Life
- My sex life is normal and without symptoms
- My sex life is normal but with symptoms
- My symptoms minimally restrict my sex life
- My symptoms moderately restrict my sex life
- My symptoms severely restrict my sex life
- My symptoms prevent any sex life at all

Section 8 – Recreational/Social Life
- My recreational/social life is normal without symptoms
- My recreational/social life is normal but with symptoms
- My symptoms minimally restricts my recreational/social life
- My symptoms moderately restricts my recreational/social life
- My symptoms severely restricts my recreational/social life
- My symptoms prevents any recreational/social life at all

Section 9 – Bladder (Urination)
- I am able to void and/or hold my urine normally
- I am able to void and/or hold my urine normally but have symptoms (i.e. frequency, urgency, discomfort)
- I experience minimal difficulty with my bladder (i.e. mildly hesitant, mildly strain or splint, mild incontinence)
- I experience moderate difficulty with my bladder (i.e. moderately hesitant, moderately strain or splint, moderate incontinence)
- I experience severe difficulty with my bladder (i.e. severely hesitant, severely strain or splint, severe incontinence)
- I am unable to void without catheterization or I have constant incontinence.

Section 10 – Bowel Movements (Defecation)
- I am able to defecate and/or hold my stool normally
- I am able to defecate and/or hold my stool normally but have symptoms (i.e. frequency, urgency, discomfort)
- I experience minimal difficulty with my bowels (i.e. mildly strain or splint, mild incontinence)
- I experience moderate difficulty with my bowels (i.e. moderately strain or splint, moderate incontinence)
- I experience severe difficulty with my bowels (i.e. severely strain or splint, severe incontinence)
- I am unable to defecate without laxatives or an enema or I have constant incontinence.

Instructions: If you have pain:
Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.

0= no pain at all          10=worst pain ever felt