

FIBROMYALGIA IMPACT QUESTIONNAIRE (FIQ)

Last name:

First name:

Age :

Todays date :

Duration of FM symptoms (years) :

Years since diagnosis of FM :

Directions: For questions 1 through 11, please check the number that best describes how you did overall for the *past week*. If you don't normally do something that is asked, place an 'X' in the 'Not Applicable' box.

Were you able to:	Always	Most	Occasionally	Never	Not Applicable
1. Do shopping?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
2. Do laundry with a washer and dryer?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
3. Prepare meals?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
4. Wash dishes / cooking utensils by hand?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
5. Vacuum a rug?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
6. Make beds?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
7. Walk several blocks?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
8. Visit friends or relatives?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
9. Do yard work?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
10. Drive a car?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
11. Climb stairs?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
Sub-total scores (for internal use only)	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>
Total score (for internal use only)	<input style="width: 40px; height: 20px;" type="text"/>				

12. Of the 7 days in the past week, how many days did you feel good?

₀ ₁ ₂ ₃ ₄ ₅ ₆ ₇

Score

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

₀ ₁ ₂ ₃ ₄ ₅ ₆ ₇

Score

(Continued)

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?

No problem with work |—————| Great difficulty with work

(for internal use only)

Score

15. How bad has your pain been?

No pain |—————| Very severe pain

Score

16. How tired have you been?

No tiredness |—————| Very tired

Score

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

Awoke well rested |—————| Awoke very tired

Score

18. How bad has your stiffness been?

No stiffness |—————| Very stiff

Score

19. How nervous or anxious have you felt?

Not anxious |—————| Very anxious

Score

20. How depressed or blue have you felt?

Not depressed |—————| Very depressed

Score

Sub-total

FIQ TOTAL