FIBROMYALGIA IMPACT QUESTIONNAIRE (FIQR)

Patient's Name ______________________________ **Age** ______ **Date** ______/______/______

DIRECTIONS For each question, select the box that best indicates how much your fibromyalgia made it difficult to do each of the following activities over the PAST 7 DAYS.

		0	1	2	3	4	5	6	7	8	9	10	
Brush or comb your hair	**No difficulty**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Very difficult**
Walk continuously for 20 minutes	**No difficulty**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Very difficult**
Prepare a homemade meal	**No difficulty**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Very difficult**
Vacuum, scrub or sweep floors	**No difficulty**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Very difficult**
Lift and carry a bag full of groceries	**No difficulty**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Very difficult**
Climb one flight of stairs	**No difficulty**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Very difficult**
Change bed sheets	**No difficulty**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Very difficult**
Sit in a chair for 45 minutes	**No difficulty**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Very difficult**
Go shopping for groceries	**No difficulty**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Very difficult**

Function sub-total = ______
(for internal use only)

DIRECTIONS For each question, select the box that best describes the overall impact of your fibromyalgia over the PAST 7 DAYS.

		0	1	2	3	4	5	6	7	8	9	10	
Fibromyalgia prevented me from accomplishing goals for the week	**Never**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Always**
I was completely overwhelmed by my fibromyalgia symptoms	**Never**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Always**

Overall Impact sub-total = ______
(for internal use only)

v. Revised Fibromyalgia Impact Questionnaire (FIQR)

FIBROMYALGIA IMPACT QUESTIONNAIRE (FIQR)

DIRECTIONS For each of the following 10 questions, select the box that best indicates the intensity of your fibromyalgia symptoms over the PAST 7 DAYS.

		0	1	2	3	4	5	6	7	8	9	10	
Please rate your level of pain	**No pain**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Unbearable pain**
Please rate your level of energy	**Lots of energy**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**No energy**
Please rate your level of stiffness	**No stiffness**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Severe stiffness**
Please rate the quality of your sleep	**Awoke well rested**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Awoke very tired**
Please rate your level of depression	**No depression**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Very depressed**
Please rate your level of memory problems	**Good memory**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Very poor memory**
Please rate your level of anxiety	**Not anxious**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Very anxious**
Please rate your level of tenderness to touch	**No tenderness**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Very tender**
Please rate your level of balance problems ...	**No imbalance**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Severe imbalance**
Please rate your level of sensitivity to loud noises, bright lights, odors and cold	**No sensitivity**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Extreme sensitivity**

Symptom sub-total = ______
(for internal use only)

FIQR TOTAL SCORE = ______
(for internal use only)

v. Revised Fibromyalgia Impact Questionnaire (FIQR)