REVISED FIBROMYALGIA IMPACT QUESTIONNAIRE (FIQR)

Last Name: **First Name:** **Age:**

Duration of FM symptoms (years) : **Time since FM was first diagnosed (years):**

Directions: For each of the following 9 questions check the box that best indicates how much your fibromyalgia made it difficult to perform each of the following activities during the past 7 days. If you did not perform a particular activity in the last 7 days, rate the difficulty for the last time you performed the activity. If you can't perform an activity, check the last box.

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**

Sub-total *(for internal use only)* ☐

Directions: For each of the following 2 questions, check the box that best describes the overall impact of your fibromyalgia over the last 7 days:

Fibromyalgia prevented me from accomplishing goals for the week	**Never** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Always**
I was completely overwhelmed by my fibromyalgia symptoms	**Never** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Always**

Sub-total *(for internal use only)* ☐

Directions: For each of the following 10 questions, select the box that best indicates your intensity of these common fibromyalgia symptoms over the past 7 days

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**

Sub-total *(for internal use only)* ☐

FIQR TOTAL *(for internal use only)* ☐