

REVISED FIBROMYALGIA IMPACT QUESTIONNAIRE (FIQR)

Last Name: _____

Duration of FM symptoms (years): _____

First Name: _____

Time since FM was first diagnosed (years): _____

Age: _____

DOMAIN 1: FUNCTION

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 0 1 2 3 4 5 6 7 8 9 10 Very difficult

WALK CONTINUOUSLY FOR 20 MINUTES

No difficulty 0 1 2 3 4 5 6 7 8 9 10 Very difficult

PREPARE A HOMEMADE MEAL

No difficulty 0 1 2 3 4 5 6 7 8 9 10 Very difficult

VACUUM, SCRUB, OR SWEEP FLOORS

No difficulty 0 1 2 3 4 5 6 7 8 9 10 Very difficult

LIFT AND CARRY A BAG FULL OF GROCERIES

No difficulty 0 1 2 3 4 5 6 7 8 9 10 Very difficult

CLIMB ONE FLIGHT OF STAIRS

No difficulty 0 1 2 3 4 5 6 7 8 9 10 Very difficult

CHANGE BEDSHEETS

No difficulty 0 1 2 3 4 5 6 7 8 9 10 Very difficult

SIT IN A CHAIR FOR 45 MINUTES

No difficulty 0 1 2 3 4 5 6 7 8 9 10 Very difficult

SHOP FOR GROCERIES

No difficulty 0 1 2 3 4 5 6 7 8 9 10 Very difficult

DOMAIN 1 SUBTOTAL: _____

DOMAIN 2: OVERALL

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 0 1 2 3 4 5 6 7 8 9 10 Always

I WAS COMPLETELY OVERWHELMED BY MY FIBROMYALGIA SYMPTOMS

Never 0 1 2 3 4 5 6 7 8 9 10 Always

DOMAIN 2 SUBTOTAL: _____

DOMAIN 3: SYMPTOMS

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

PLEASE RATE THE LEVEL OF PAIN

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

PLEASE RATE YOUR LEVEL OF ENERGY

Lots of energy 0 1 2 3 4 5 6 7 8 9 10 No energy

PLEASE RATE YOUR LEVEL OF STIFFNESS

No stiffness 0 1 2 3 4 5 6 7 8 9 10 Severe stiffness

PLEASE RATE THE QUALITY OF YOUR SLEEP

Awoke well rested 0 1 2 3 4 5 6 7 8 9 10 Awoke very tired

PLEASE RATE YOUR LEVEL OF DEPRESSION

No depression 0 1 2 3 4 5 6 7 8 9 10 Very depressed

PLEASE RATE YOUR LEVEL OF MEMORY PROBLEMS

Good memory 0 1 2 3 4 5 6 7 8 9 10 Very poor memory

PLEASE RATE YOUR LEVEL OF ANXIETY

Not anxious 0 1 2 3 4 5 6 7 8 9 10 Very anxious

PLEASE RATE YOUR LEVEL OF TENDERNESS TO TOUCH

No tenderness 0 1 2 3 4 5 6 7 8 9 10 **Very tender**

PLEASE RATE YOUR LEVEL OF BALANCE PROBLEMS

No imbalance 0 1 2 3 4 5 6 7 8 9 10 **Severe imbalance**

PLEASE RATE YOUR LEVEL OF SENSITIVITY TO LOUD NOISES, BRIGHT LIGHTS, ODORS, AND COLD

No sensitivity 0 1 2 3 4 5 6 7 8 9 10 **Extreme sensitivity**

DOMAIN 3 SUBTOTAL: _____

SCORING:

- 1) Sum the scores for each of the 3 domains (function, overall, and symptoms).
- 2) Divide domain 1 score by 3, leave domain 2 score unchanged, and divide domain 3 score by 2.
- 3) Add the 3 resulting domain scores to obtain the total FIQR score.

<p>DOMAIN 1 SUBTOTAL _____ $\div 3 =$ _____</p> <p>DOMAIN 2 SUBTOTAL _____ CARRY OVER SUBTOTAL = _____</p> <p>DOMAIN 3 SUBTOTAL _____ $\div 2 =$ _____</p>		<div style="border: 1px solid black; width: 100%; height: 40px; margin: 0 auto;"></div> <p>TOTAL FIQR SCORE</p>
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