

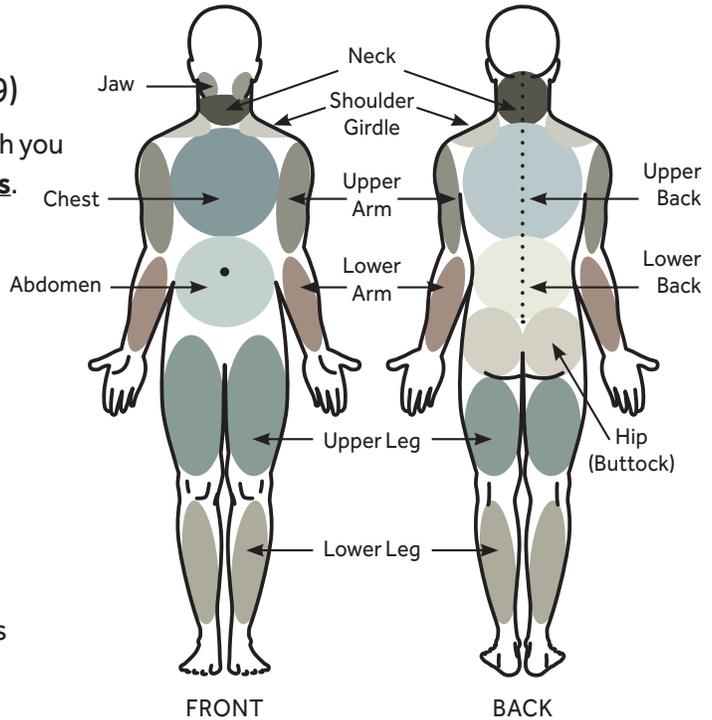
Widespread Pain Index (WPI)

(1 point per check box; score range: 1–19)

Please check the boxes below for each area in which you have had pain or tenderness **during the past 7 days**.

- | | |
|---|--|
| <input type="checkbox"/> Shoulder girdle, left | <input type="checkbox"/> Lower leg left |
| <input type="checkbox"/> Shoulder girdle, right | <input type="checkbox"/> Lower leg right |
| <input type="checkbox"/> Upper arm, left | <input type="checkbox"/> Jaw left |
| <input type="checkbox"/> Upper arm, right | <input type="checkbox"/> Jaw right |
| <input type="checkbox"/> Lower arm, left | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Lower arm, right | <input type="checkbox"/> Abdomen |
| <input type="checkbox"/> Hip (buttock) left | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Hip (buttock) right | <input type="checkbox"/> Upper back |
| <input type="checkbox"/> Upper leg left | <input type="checkbox"/> Lower back |
| <input type="checkbox"/> Upper leg right | <input type="checkbox"/> None of these areas |

WPI score: _____



Symptom Severity (score range: 1–12)

For each symptom listed below, use the following scale to indicate the severity of the symptom **during the past 7 days**.

	Points	No problem	Slight or mild problem	Moderate problem	Severe problem
		0	1	2	3
A. Fatigue		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Trouble thinking or remembering		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Waking up tired (unrefreshed)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the **past 6 months** have you had any of the following symptoms?

	Points	0	1
A. Pain or cramps in lower abdomen		<input type="checkbox"/> No	<input type="checkbox"/> Yes
B. Depression		<input type="checkbox"/> No	<input type="checkbox"/> Yes
C. Headache		<input type="checkbox"/> No	<input type="checkbox"/> Yes

SS score: _____

Additional criteria (no score)

Have the symptoms listed on this sheet, and widespread pain been present at a similar level for **at least 3 months**?

- No Yes

TOTAL score: _____

PAIN CATASTROPHIZING SCALE

Name _____ Date _____

Age _____ Gender M F

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

Instructions

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

RATING	0	1	2	3	4
MEANING	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time

When I am in pain...

STATEMENT	RATING
1 I worry all the time about whether the pain will end.	
2 I feel I can't go on.	
3 It's terrible and I think it's never going to get any better.	
4 It's awful and I feel that it overwhelms me.	
5 I feel I can't stand it anymore.	
6 I become afraid that the pain will get worse.	
7 I keep thinking of other painful events.	
8 I anxiously want the pain to go away.	
9 I can't seem to keep it out of my mind.	
10 I keep thinking about how much it hurts.	
11 I keep thinking about how badly I want the pain to stop.	
12 There's nothing I can do to reduce the intensity of the pain.	
13 I wonder whether something serious may happen.	