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.

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 re Tm**

Sub-total ***(for internal use only)***

FIQR TOTAL ***(for internal use only)***

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