APPENDIX **B**

MODIFIED FIBROMYALGIA ASSESSMENT

Investigator Copy

Read the following instructions: i will be asking you questions regarding your health over the past four weeks. Place your answers on this answer sheet, remembering to the best of your ability. You need only to mark one appropriate category for each question - "All Days", "Most **Days**", "**Some** Days", "Few Days", or "No Days", as depicted on your answer sheet.

SECTION 1: _ Functional Mobility "During the past four weeks..."

1. How often were you physically able to drive **a** car or use public transportation?

2. How often were you out of the house for at least part of the day?

3. How often were you able to run errands in the neighborhood?

4. How often did someone have to assist you to get around outside you home?

5. How often were you in a bed or chair for most of the day?.

6. How often were you able to do regular exercise that is a normal part of your schedule?

7. Were you able to walk several blocks or climb a few flights of stairs?

8. Did you have trouble bending, lifting or stooping?

9. Did you have trouble either walking one block or climbing one flight of stairs?

10. Were you unable to walk unless assisted by another person or by a cane, crutches or walker?

11. Did you have difficulty sitting for longer than half an hour?

12. Did you have difficulty standing for longer than half an hour?

SECTION 2: _ Fibromyalgia Pain "During the past four weeks..."

1. How often did you have any pain at all?
2. How often did you have severe pain?
3. How often did you have pain in two or more particular spots at the same time?
4. How often did your morning stiffness resolve within one hour from the time you woke up?
5. How often does your pain interfere with what you want to do?
6. How often did your pain **make** it difficult for you to sleep?

SECTION 3: __ Sleet **8** Fatigue "During the past four weeks..."

1. How often did you have difficulty falling asleep at night?
2. How often did you sleep through the night?
3. How often did you wake up earlier than you planned?
4. How often did you feel well rested in the morning?
5. How often did you feel tired during the day?
6. How often did you feel that you tired easily?
7. How often did you feel too tired to do what you wanted to do?

SECTION 4: _ Work "During the past four weeks..."

**Note: Complete this section only if you are currently involved in paid work, housework, schoolwork or volunteer work. "All Days" would coincide with the number of days usually worked or normal workload.

1. How often were you able to do any paid work, housework, schoolwork, or volunteer work?

2. On the days that you did work, how often did you have to work a shorter day or less time than usual?

3. On the days that you did work, how often were you able to do your work as carefully and accurately as you would like?

4. On the days that you did work, how often did you have to change the way your paid work, housework, schoolwork, or yolunteer work is usually done?

SECTION 5: _ Level of Tension "During the past four weeks..."

1. How often have you felt tense or highstrung?

2. How often were you able to relax without difficulty?

3. How often have you felt calm and peaceful?

4. How often have you felt relaxed and free of any tension?

5. Do you feel you are getting better?

6. Do you feel you are getting worse?

7. Do you feel you are staying the same?

MODIFIED FIBROMYALGIA ASSESSMENT

Subject Answer Sheet

Subject #

SECTION 1: Functional Mobility

	All Days	Most Days	Some Days	Few Days	No Days
1. TRANSPORTATION					
2. OUT OF HOUSE					
3. ERRANDS					
4. ASSISTANCE					
5. BED/CHAIR					
6. EXERCISE					
7. STAIRS/BLOCKS					
8. BEND/LIFT/STOOP					
9. ONE STAIR/ONE BLOCK					
10. CANE/CRUTCHES/WALKER					
11. SITTING					
12. STANDING					

SECTION 2: Fibromyalgia Pain

	All Days	Most Days	Some Days	Few Days	No Days
1. PAIN					
2. ' SEVERE PAIN					
3. PAIN-TWO SPOTS					
4. MORNING STIFFNESS					
5. PAIN-INTERFERE					
6. SLEEP					

SECTION 3: _ Sleep & Fatigue

	All Days	Most Days	Some Days	Few Days	No Days
1. FALL ASLEEP					
2. SLEEP THROUGH NIGHT					
3. WAKE EARLY					
4. RESTED					
5. TIRED					
6. EASILY TIRED					
7. TOO TIRED					

SECTION 4: _ Work

1. WORK
2. SHORTER SCHEDULE
3. CAREFUL WORK
4. CHANGE WORK SECTION 5:

Level of Tension

1. TENSE
2. RELAXATION
3. CALM/PEACEFUL
4. TENSION-FREE
5. BETTER
6. WORSE
7. SAME

PAIN QUESTIONNAIRE

1. How much pain do you feel RIGHT NOW?
   Circle the number on the scale below at the appropriate point.

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

No pain — Very severe pain

2. Please place an X on each area in the diagram below where you are presently feeling pain: