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ORIGINAL ARTICLE

Assessing Impairment and Disability for Syndromes Presenting With Chronic Fatigue

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Many disability claims are based on the subjective symptom of fatigue, which can be caused by a wide spectrum of diagnoses including fibromyalgia, chronic fatigue syndrome and cardiopulmonary diseases. Chronic pain is very often a compounding problem. It is vital for every insurer to have fair and objective criteria to distinguish between invalid claims and those with merit. This review article proposes objective tools and parameters to achieve this goal.

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INTRODUCTION

Fibromyalgia (FM) and the Chronic Fatigue Syndrome (CFS) cover a wide spectrum of signs and symptoms, which are virtually exclusively subjective in nature. The emphasis in FM is on pain where the emphasis in CFS is on persistent fatigue. There are many similarities between the two conditions (Table 1). Over many years the presenting symptom has varied and there is a significant body of opinion that believes that the CFS and FM are similar, if not identical conditions. According to Yunus,[1] these two syndromes form part of a spectrum of conditions classified as Neuroendocrine Immune Dysfunction, as demonstrated in Figure 1. Both syndromes are poorly understood in terms of causation, pathophysiology, natural history, and the appropriate medical management. Research has shown that CFS and FM also share demographic features, symptoms and common physical examination findings (Figure 1).

The clinical syndromes and diagnostic criteria of these conditions are well described in medical literature,[2,3] and are beyond the scope of this paper. These syndromes present challenges to disability assessment in the following ways:

- There is a significant financial benefit, which accrues from a certain level of functional impairment and the impact that this has on the claimant's ability to perform the normal activities of daily living and their occupation.
- That to remain ill has financial benefit.
- To date there have not been assessment cri-

Table 1. Symptom Similarities of Chronic Fatigue Syndrome and Fibromyalgia

	Fibromyalgia	Chronic Fatigue Syndrome
Symptoms		
• Wide spread pain	××	×
• Pain localized mainly at tender points	××	×
• Decrease in pain threshold	××	×
• Sleep disturbance	×	×
• Fatigue	×	×××
• Anxiety	×	×
• Depression	××	×××
• Neurocognitive dysfunction	××	××
• Exercise intolerance	×	×××
• Headache	×	×
• Irritable Bowel Syndrome	×	×
• Joint Stiffness	×	×
Signs		
• Tender points	×××	×
• Lymphadenopathy	—	×
• Pharyngitis	—	×
• Fever	—	×
Clinical examination		
Generally non-contributory other than in Chronic Fatigue Syndrome there is in the initial stages symptoms and signs of a viral infection.	×	×
Special investigations		
Non-contributory	—	—

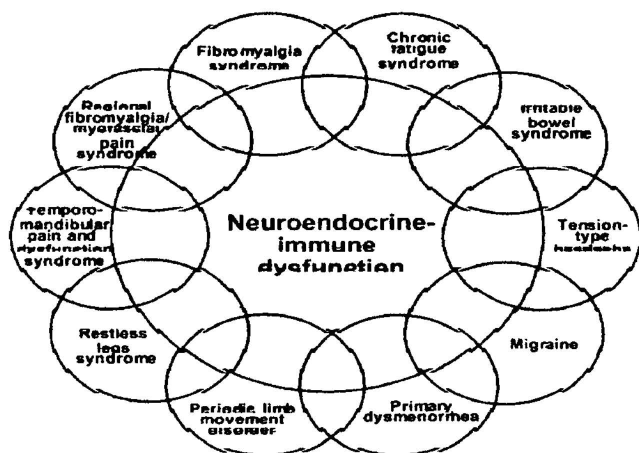

Figure 1.

teria to assess functional impairment for the CFS and FM, which are aimed at assessing the exercise and work tolerance of the claimant in an objective and quantitative way.

- Admission of claims in claimants who are not objectively assessed reinforces the condition and in so doing does the claimant and society a disservice. This fosters somatization and medicalization of these conditions with the concomitant negative effects on the health care system and the economy.

ASSESSMENT OF FUNCTIONAL IMPAIRMENT

Introduction

The symptoms of patients suffering from CFS and FM are mainly subjective in nature, which complicates attempts to objectively quantify the degree of impairment. Furthermore, signs and symptoms of FM are found in the normal population who are still actively employed.[4,5] Hidding et al[6] also reported "discordance between self-report questionnaires and observed functional disability" as a most striking feature of FM. It is also evident that only minorities of patients are unable to work,[7] and that most patients are able to continue working with workplace adaptation.[4]

The above makes it imperative that some form of objective measurement be incorporated into the impairment assessment of these subjective syndromes. This will not only result in increased fairness in distinguishing between non-valid claims and those with merit, but will help maintain affordable insurance premiums to all. Impairment is defined by the AMA as "conditions that interfere with an individual's activities of daily living."[8] The World Health Organization defines it as "any loss or abnormality of psychological, physiological, or anatomical structure or function."[9]

The assessment of impairment in function, is the primary role of the Independent Medical Examiner (IME). The IME should be in

possession of all medical documentation to date, and should utilise the assessment tools as described in the following sections to quantify impairment.

Pre-assessment Criteria

Functional impairment can only be assessed once the patient has received optimal treatment available, the condition has stabilized and the point of maximal medical improvement (MMI) has been reached.[8] According to international literature, no specific period of time could be established that could be regarded as an optimal period of treatment prior to MMI having been reached.

However, it is reasonable to assume that no clinician can prescribe all the treatment modalities agreed upon to be considered as optimal treatment, during a period of less than 2 *years*. This is necessary to allow different classes of medication to take full effect, to adjust dosages if indicated, and to institute a proper rehabilitation and work integration/ adaptation program. The IME must also ensure that the diagnosis was made correctly and according to the Center for Disease Control (CDC) criteria for CFS, and the American College of Rheumatology (ACR) criteria for FM.

Quantifying Functional Impairment

The spectrum of symptoms that may lead to impairment include the following:[11,12]

- Pain
  - Headache
  - Myofascial pain
  - Joint pain
  - Back pain
- Fatigue
- Cognitive impairment, mainly decreased memory, concentration, persistence and pace.
- Sleep disorders
- Mood disorders
- Various somatic symptoms like irritable bowel syndrome etc.

Table 2 summarizes the suggested assessment tools to be utilized to quantify impairment severity due to the symptoms experienced, and is adapted from the American Academy of Disability Evaluating Physicians (AADEP) position papers on CFS and FM.[7,10]

Table 2. Evaluating Impairment Due to CFS or FM

Symptoms	Assessment Tools
Pain • Headache • Myofascial pain • Joint pain • Back pain	• Pain intensity/frequency grid • Pain questionnaire • Pain diagram • Objective proof of pain therapy • Fibromyalgia impact questionnaire (FIQ) • ADL impairment • ROM impairment where indicated
Fatigue	• ADL impairment • Exercise capacity
Cognitive impairment	• Neuropsychiatric analysis for impairment in memory, concentration, persistence and pace
Mood disorders	• Psychiatric evaluation of: • Social interaction • Activities of daily living • Task completion (concentration, persistence, pace) • Adaptation to work stress
Sleep disorders	• Assess according to AMA Guides, 4th Edition
Somatic symptoms	• Assess according to AMA Guides, 4th Edition

In addition to the assessment criteria as suggested by AADEP (Table 2), our working group have included the following objective parameters:

- Objective proof of pain therapy
- Exercise capacity measurement

We also propose an overall evaluation of the validity of data, as described in section 4. More specific details of the various impairment assessment tools are specified in Table 2.

i. Pain Intensity/Frequency Grid (PIFG)

Pain intensity should be classified as either minimal, slight, moderate, or marked, according to the criteria as used by the American Medical Association (AMA).[8] The use of non-

narcotic or narcotic analgesics serves as an important differentiator. The frequency of pain experienced should also be documented as intermittent, occasional, frequent, or constant.

The above categorization of pain intensity and frequency should be done by the examining physician, on information received by direct questioning of the patient, as well as collateral information received from family, friends, and/or the employer.

ii. Pain Questionnaire (Appendix A)

Various pain questionnaires are available which have been proven in international research to be useful tools in the quantification of the intensity of pain. We recommend the pain questionnaire of Hyman,[13] as it also assesses the patient's:

- motivation
- likelihood of responding to a rehabilitation program
- expectations of disease outcome
- work satisfaction

Also, these questions give an indication of the presence and extent of psychiatric overlay. If the pain is made worse by all physical activities such as bending, kneeling, sitting, and lying as indicated by the questionnaire, the validity of the data should be questionable, as certain movements should have no effect on the pain.

iii. Pain Diagram (Appendix B)

The pain diagram should be completed by the claimant. The important data obtained from the type of pain and its distribution should make physiological and pathological sense, and fit the patient's diagnosis. If not, symptom magnification or malingering should be considered.

iv. Objective Proof of Pain Therapy

In addition to the pain intensity/frequency grid, impairment in Activities of Daily Living (ADL) and the Fibromialgia Impact Questionnaire (FIQ), which are all subjective measures of pain, the assessor should substantiate the degree of pain by requesting the following objective evidence:

- Extracts from clinical records of the treating family physician to verify the number and frequency of consultations to seek treatment and/or prescriptions for pain relief.
- Copies of such prescriptions for pain relief medication, or copies of pharmacy bills.

v. Self-Report Questionnaires

Various self-report questionnaires exist to evaluate subjective complaints like pain, tiredness, depression, etc. Although these questionnaires are of limited value because of a lack of objectivity, it is felt that the information gained can contribute significantly to the holistic assessment of the disabled individual. It is recommended that the FIQ[14] be used in all cases. Scrutinizing the contents of the FIQ after completion may yield valuable information about the extent of the client's symptomatology. A total score for the questions exceeding 70 out of a possible total of 82 may indicate symptom magnification, somatization, or malingering.

vi. Impairment in Activities of Daily Living (ADL)

Claimants should be requested to complete a questionnaire on the impact of the disease on their abilities to cope with activities of daily living. Examples of ADL are given in Table 3. The client's level of impairment in the activities of daily living should be quantified as follows:

CATEGORY:

- No impairment. Functions as any normal person.
- Mild impairment. Has difficulty with the specific activity, but can cope.
- Moderate impairment. Can only do the specific activity with discomfort and effort.

Table 3. Activities of Daily Living, with Examples (8)

Activity	Example
Self-care, personal hygiene	Bathing, grooming, dressing, eating
Communication	Hearing, speaking, reading, writing, using keyboard
Physical activity	Intrinsic: Standing, sitting, reclining, walking, stooping, squatting, kneeling, reaching, bending, twisting, leaning Functional: Carrying, lifting, pushing, pulling, climbing, exercising
Sensory function	Hearing, seeing, tactile feeling, tasting, smelling
Hand functions	Grasping, holding, pinching, percussive movements, sensory discrimination
Travel	Riding, driving, traveling by airplane, train, or car
Sexual function	Participating in desired sexual activity
Sleep	Having a restful sleep pattern
Social and recreational activities	Participating in individual or group activities, sports, hobbies

- Marked impairment. Needs assistance with the activity.
- Extreme impairment. The specific activities are impossible to do.

vii. Range of Motion Impairment

FM may cause joint or back pain, which may limit the normal range of motion of certain joints or the spine. This range of motion (ROM) impairment should be recorded with a goniometer or inclinometer as described in the AMA Guides, 4th Edition, Chapter 3. **Pain with no ROM limitation constitutes no impairment.**

viii. Exercise Capacity Testing

The AMA Guides suggests that fatigue, as a symptom of respiratory or cardiac disease, should be objectively assessed by quantifying impairment in exercise capacity. This is done by using one of various graded exercise protocols on either a treadmill or cycle-ergometer, as described in the Guides on p171, to determine maximal energy expenditure in metabolic equivalents (METS). METS represents the multiples of resting metabolic energy, which the patient can achieve with maximum effort exercise testing, with one MET being equal to an oxygen consumption of 3.5 ml/kg/min. Research has shown that it is reasonable to expect a person to maintain 40% of his maximal exercise capacity for an 8-hour working day.[8] Therefore, calculating 40% of the patient's maximal workload and comparing it to the work descriptions that could be maintained (Table 4) would classify the claimant's abilities on physical grounds into either capable of doing light work, moderate work, heavy, very heavy, or arduous work.

Table 4. Oxygen and Energy Requirements for Different Work Intensities

Work Intensity for 70 kg Person	Oxygen Consumption (ml/kg/min)	METS
Light work	7	<2
Moderate work	8–15	2–4
Heavy work	16–20	5–6
Very heavy work	21–30	7–8
Arduous work	>30	>8

The definitions of these different work intensities can be obtained from the USA Dictionary of Occupational Titles.[15]

It is recommended that exercise capacity testing be utilized to quantify the physical fatigue, or lack of energy, of a FM or CFS patient in the manner described above. Due to the fluctuating nature of FM and CFS symptoms, the client should undergo exercise testing on at least two occasions at least one month apart. Clients who meet the minimum recommended METS level for their type of work (Table 4), should not be considered disabled on the basis of fatigue, but should be evaluated according to any other criteria applicable (Table 2).

OTHER IMPAIRMENTS

Should the client suffer from significant impairment due to other symptoms of these syndromes, for example, cognitive impairment, or mood or sleep disorder, these impairments should be evaluated according to the appropriate section in the AMA Guides, 4th Edition.

Validity of Data

Because of the subjective nature of the symptoms of CFS and FM, the examining physician should always, before deciding on the extent of permanent impairment, attempt to validate the authenticity of the data obtained. This could be compared to the Waddell signs, which indicate non-organic causes for low backache.[16] If two or more of the following are present, symptom magnification or malingering may be considered.

1. A normal clinical examination, with specific reference to the minimum number of tender points needed to diagnose FM according to the ACR criteria.
2. Positive distraction test—this refers to a specific tender point(s) that elicits pain upon direct pressure, but fails to reproduce the same response when the same pressure is applied while the patient's attention is distracted.
3. A normal psychometric evaluation.
4. Total non-physiological or non-pathological pain distribution or type of pain as evidenced by the pain questionnaire and/or pain diagram. This should also apply when the pain distribution and nature does not fit the clinical diagnosis.
5. Non-correlation of exercise capacity (METS) achieved with pulse rate response and workload achieved. A patient complaining of excessive tiredness at low workloads and low pulse rate acceleration should be viewed with suspicion in the absence of cardiological and/or pulmonological disease. Patients with true impairment in exercise capacity will show excessive pulse rate acceleration at low workloads.
6. Total FIQ score exceeding 70 out of a possible total of 82 points.

Format of Report

The medical examiner should supply the employer and/or insurer with a complete medical report covering all the aspects mentioned in Table 5.

Assessing Disability

Disability is the alteration of capability to meet personal, social or occupational demands due to an impairment.[8] Disability assessment is a legal and not a medical decision, taken by a panel of experts including a

- medical advisor
- legal advisor, and
- claims consultant.

The insurer assesses a disability claim by carefully evaluating the following four categories:

1. Claimant
2. Job description
3. Disability clause conditions
4. Medical condition

1. Claimant

Factors that need to be considered include:

- gender and age
- experience and qualifications
- income, and
- previous occupations.

2. Job Description

Generally, occupations can be classified into the following categories:

- Manual
- Operative
- Clerical
- Supervisor in clerical field
- Technical
- Supervisor in technical field

Table 5.

1. Diagnosis
   - Diagnosis should be based on the 1990 ACR criteria
   - Cite the historical and current physical findings that support the diagnosis
2. Treatment and response to therapy
   Response to therapy
   a) Pharmacological intervention
      Name type of drugs and dosages prescribed
      Note period of treatment, compliance and response to therapy
      Has the point of MMI been reached? Give details
   b) Non-pharmacological intervention
      - Cognitive-behavioural therapies
        - Cognitive-behavioural therapies
        - Exercise-based programs
        - Other non-pharmacological treatments
      Note period of treatment, compliance and response to therapy
      Has the point of MMI been reached? Give details
3. Functional impairment
   Describe the frequency and severity of symptoms experienced
   Provide adequate details in terms of the assessment tools discussed above:
   - Pain:
     - PIFG
     - Initial pain questionnaire
     - Pain diagram
     - Objective proof of pain therapy
     - FIQ
       - ADL impairment assessment
       - ROM impairment if indicated
     - Fatigue:
       - ADL impairment
       - Exercise capacity test
     - Cognitive impairment:
       - Neuropsychiatric analysis
     - Mood disorders:
       - Psychiatric evaluation
     - Somatic symptoms:
       Impairment assessment as per AMA Guides 4th Edition
4. Current abilities
   Describe the usual activities of daily living (ADL's) that the claimant is still capable of doing:
   - Working
   - Recreation
   - Shopping
   - Travel
   - Housework
   - Self care
5. Workplace adaptation
   - Impact on activities at work
   - Is intervention at the workplace/change of occupation possible?
   - What effect has therapy had on work ability?
   - Has an occupational therapy assessment been done?

- Managerial
- Specialized, and
- Mixed

The percentage of time spent supervising, sitting down, standing or doing manual labor should be specified by the employer. The METS requirements of the specific type of job in question is matched with that of the exercise capacity test achieved by the claimant.

3. Disability Clause Conditions

Precise disability clause wordings differ from one insurer to the next, but generally the following types of disability coverage are sold:

3.1 According to Type of Work

3.1.1 Own Occupation

A claim is considered when a claimant cannot do his own specific job. This is a more expensive type of disability cover and is usually sold to professional people. In these cases the exact job description of each claimant is evaluated in terms of his or her medical impairment.

3.1.2 Own/Similar Occupation

A claim is considered when a claimant is unfit to do his or her own occupation, and will also not be fit to perform a similar occupation that he or she may reasonably be expected to follow, taking into account education, training, and experience.

3.1.3 Any Occupation

This is a cheap type of disability cover with a very wide policy definition, and the degree of disability has to be very high to qualify for a claim. Here qualifications, experience, income, etc., are irrelevant, and the claimant literally has to be unable to do any work, in other words, even simple tasks like access control to buildings/venues, selling tickets, etc.

3.2. According to Duration of Disability

3.2.1 Total and Permanent Disability

The disease has to be optimally treated and still result in impairment to such a degree that the person is totally and permanently unfit to work. The impairment must be irreversible and must permanently prevent the patient from working; diseases that are treatable (eg, hypertension) or periodic in nature (eg, epilepsy) therefore do not qualify as causes for disability in this category.

3.2.2 Total Disability

In this category a monthly income is provided and periodic medical review is required to determine sustained disability. Temporary disability due to treatable or episodic types of diagnoses (eg, acute backache) may qualify for a claim provided the other parameters of disability assessment are met.

4. Medical Condition

The medical condition is assessed by the IME according to the information as described previously. It is therefore important to supply as much medical information as possible in order to be able to make an informed decision.

Availability of Employment

It is important to realize that disability insurance only insures the ability to work, and not the availability of alternative employment or the ability to commute to work.

REFERENCES

1. Yunus MB. Unpublished data. Paper presented at AADEP International Fibromyalgia Symposium, Tucson, USA. November 1999.
2. Komaroff AL, Buchwald DS. Chronic Fatigue Syndrome: an Update: *Ann Rev Med.* 1998;49:1–13.
3. Strauss SI, ed. Harrison's Principles of Internal Medicine, 14th Ed. McGraw-Hill, New York 1998: 2483–2485.
4. Croft P, Schollum J, Silman A. Population study of tender point counts and pain as evidence of Fibromyalgia. *BMJ.* 1994;309:696–699.
5. Wolfe F, Ross K, Anderson J, et al. The prevalence and characteristics of fibromyalgia in the general population. *Arthritis Rheum.* 1995;38:19–28.
6. Hidding A, Vansanten M, Deklerk E, et al. Comparison between self-report measures and clinical observations of functional disability in ankylosing spondylitis, rheumatoid arthritis and fibromyalgia. *J Rheumatol.* 1994;21:818–823.
7. Alpern HL, Ranavaya MI, Govindan C, et al. Chronic Fatigue Syndrome: Impairment and Disability Issues. (AADEP Position Paper) Chicago, IL, 1998.
8. American Medical Association. Guides to the Evaluation of Permanent Impairment, 4th Ed. Chicago, IL. AMA June 1993, p310, figure 2.
9. WHO International Classification of Impairments, Disabilities and Handicaps. Geneva, Switzerland: WHO; 1980.
10. AADEP. Fibromyalgia, Impairment and Disability Issues (AADEP Position Paper) Chicago, IL, 1999.
11. Holmes GP, Kaplan JE, Gantz NM, et al. Chronic Fatigue Syndrome: a working case definition. *Ann Intern Med.* 1988;108:387–389.
12. Reilly PA. The differential diagnosis of generalised pain. *Clin Rheumatol.* 1999;13:391–401.
13. Hyman F at AADEP 13th Annual Meeting, Tucson, AZ, November 1999.
14. Burckhardt CS, Clark SR, Bennett RM. The Fibromyalgia impact questionnaire: Development and validation. *J Rheumatol.* 1999;18(5):728–733.
15. US Department of Labor, Employment and Training Administration. Dictionary of Occupational Titles, 4th ed. Indianapolis, IN, 1986;101–102.
16. Waddell G, McCulloch JA, Kummel I, et al. nonorganic physical signs in low-back pain. *Spine.* 1980;5(2):117–125.

APPENDIX A

Chronic Pain: Questionnaire

To Our Patient

Please fill this out prior to seeing the doctor. This helps us to help you.

When did your current problem begin?

____

What were you doing when you first hurt yourself?

____

Where was your pain/problem **at the beginning**?

____

Since the beginning, has your pain/problem been constant or intermittent?

____

How many previous episodes of this problem have you had?

____

If you have been seen at any other office/clinic/hospital/emergency room, please answer the following:

When and by whom were you previously treated?

____

What tests or x-rays were done for this?

____

What were the diagnoses given for your problem?

____

List any medicines which you have taken for this problem.

____

List any therapies you have tried for this problem.

____

Did anything that you have previously tried help or hurt your pain/problem?

____

For each of the next three questions, please indicate on the line the number between 0 and 100 that best describes your pain. A zero (0) would mean "no pain" and a one hundred (100) would mean "pain as bad as it could be." **Only write one number on each line.**

Your pain right now ______________________

Your typical or average pain ______________________

Your pain at its worst ______________________

For the questions below **select only one number.**

Please indicate how anxious (e.g. tense, uptight, irritable, fearful, difficulty in concentrating/relaxing) you have been feeling **during the last week.**

Not at all anxious	1	2	3	4	5	6	7	8	9	10	Extremely anxious

Please indicate how depressed (e.g. down-in-the-dumps, sad, down-hearted, in low spirits, pessimistic, feelings of hopelessness) you have been feeling **during the last week.**

Not at all depressed	1	2	3	4	5	6	7	8	9	10	Extremely depressed

Please indicate how much you agree with the statement: If I become sick, I have the power to make myself well again.

Completely disagree	1	2	3	4	5	6	7	8	9	10	Completely agree

Please indicate how much you agree with the statement: Health professionals, like my doctor, control my health.

Completely disagree	1	2	3	4	5	6	7	8	9	10	Completely agree

Please indicate how much you agree with the statement: I cannot do physical activities which might make my pain worse.

Completely disagree	1	2	3	4	5	6	7	8	9	10	Completely agree

If you are currently employed or out on work leave, please complete the following questions.

Please indicate how much you enjoy the tasks involved in your job.

Hardly ever	1	2	3	4	5	6	7	8	9	10	Almost always

Please indicate how well you get along with your fellow workers.

Don't get along well at all	1	2	3	4	5	6	7	8	9	10	Get along very well

Please indicate how certain you are that you will be able to do your normal work within 3 months.

Not certain at all	1	2	3	4	5	6	7	8	9	10	Very certain

In the table below, place a checkmark into each box that identifies where your pain is and how it feels.

	Head	Neck	Back	Arms	Legs
Right side					
Left side					
Both sides					
Sharp					
Dull					
Aching					
Throbbing					
Burning					
Stabbing					
Pins and needles					

How often does your pain occur (circle only one)?
a) constantly (90% of the time)
b) frequently (75% of the time)
c) intermittently (50% of the time)
d) occasionally (25% of the time)

Would you describe your pain as (circle only one):
a) minimal—an annoyance
b) slight—tolerable, some limitation in activities that produce pain
c) moderate—a marked limitation in all activities that produce pain
d) severe—precludes all activities that produce pain

If you have numbness, how often (circle only one)?
a) constantly (90% of the time)
b) frequently (75% of the time)
c) intermittently (50% of the time)
d) occasionally (25% of the time)

Are you currently (circle only one):
a) working at your regular job
b) working at home
c) going to school
d) working in a modified capacity at your job/home/school
e) unemployed
f) retired
g) out on disability from work (if so, how long __________)

In the table below, indicate with a checkmark whether any of these activities has an effect on your symptoms.

	Better	Worse	No Effect
Bending			
Squatting			
Crawling			
Climbing			
Crouching			
Kneeling			
Reaching			
Pushing			
Pulling			
Sitting			
Standing			
Rising from sitting			
Rising from lying			
Turning			
Lying on back			
Lying on stomach			
Sex			
Sleeping			
Coughing			
Sneezing			
Walking			
Running			
Lifting			
Morning			
Evening			

CHRONIC PAIN: FOR PATIENTS WITH BACK OR LEG PROBLEMS (Continued)

When your back or leg hurts, you may find it difficult to do some of the things you normally do. This list contains some sentences people have used to describe themselves when they have back pain or sciatica. When you read them, you may find that some stand out because they describe you today. **As you read the list, think of yourself *today*.** When you read a sentence that describes you today, put a check in the yes column. If the sentence does not describe you today, check the no column.

Yes	No	
		1. I stay at home most of the time because of my back problem or leg pain (sciatica).
		2. I change my position frequently to try and get my back or leg comfortable.
		3. I walk more slowly than usual because of my back or leg pain (sciatica).
		4. Because of my back problem, I am not doing any of the jobs that I usually do around the house.
		5. Because of my back problem, I use a handrail to get upstairs.
		6. Because of my back problem, I have to hold onto something to get out of an easy chair.
		7. I get dressed more slowly than usual because of my back problem or leg pain.
		8. I only stand for short periods of time because of my back problem or leg pain.
		9. Because of my back problems, I try not to bend or kneel down.
		10. I find it difficult to turn over in bed because of my back problem or leg pain.
		11. My back or leg is painful almost all of the time.
		12. I have trouble putting on my socks (or stockings) because of the pain in my back or leg.
		13. I only walk short distances because of my back or leg pain.
		14. I sleep less well because of my back problem.
		15. I avoid heavy jobs around the house because of my back problem.
		16. Because of my back problem, I am more irritable and bad tempered with people than usual.
		17. Because of my back problem, I go upstairs more slowly than usual.
		18. Because of my back problem, my sexual activity is decreased.
		19. I keep rubbing or holding areas of my body that hurt or are uncomfortable.
		20. Because of my back problem I am doing less of the daily work around the house than I would usually do.
		21. I often express concern to other people over what might be happening to my health.

APPENDIX B

PAIN DIAGRAM

In the diagrams below, mark the areas of the body, using the symbols, where you have experienced any of the following symptoms **this past week**.

ACHING	BURNING	STABBING	PINS & NEEDLES	NUMBNESS
XXXXXX	======	//////////////////	OOOOOOOO	———
XXX	———	//////////////////	OO	———