# SYMPTOM IMPACT QUESTIONNAIRE (SIQR)

**Last Name:** **First Name:** **Age:**

**Directions:** For each question, place an "**X**" in the box that best indicates how much difficulty you have experienced in doing the following activities during the past 7 days.

| | | |
|---|---|---|
| Brush or comb your hair | **No difficulty** | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very difficult** |
| Walk continuously for 20 minutes | **No difficulty** | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very difficult** |
| Prepare a homemade meal | **No difficulty** | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very difficult** |
| Vacuum, scrub or sweep floors | **No difficulty** | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very difficult** |
| Lift and carry a bag full of groceries | **No difficulty** | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very difficult** |
| Climb one flight of stairs | **No difficulty** | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very difficult** |
| Change bed sheets | **No difficulty** | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very difficult** |
| Sit in a chair for 45 minutes | **No difficulty** | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very difficult** |
| Go shopping for groceries | **No difficulty** | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Very difficult** |

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

**Directions:** For each question, check the <u>one</u> box that best describes the overall impact of any medical problems over the last 7 days:

| | |
|---|---|
| Was able to accomplish most set goals for week | **Always** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Never** |
| Was overwhelmed by symptoms | **Never** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Always** |

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

**Directions:** For each question, check the one box that best indicates the intensity, during the past 7 days, of the following common symptoms.

| | | | |
|---|---|---|---|
| How severe has your pain been? | **No pain** | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | **Unbearable pain** |
| How much were you fatigued or lacking in energy? | **Lots of energy** | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | **No energy** |
| How much has stiffness bothered you? | **No stiffness** | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | **Severe stiffness** |
| How did you feel on awakening in the morning? | **Well rested** | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | **Very tired** |
| How depressed or blue have you felt? | **No depression** | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | **Very depressed** |
| How much has memory and / or concentration been a problem? | **Not a problem** | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | **Severe problem** |
| How stressed or anxious have you felt? | **Not anxious** | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | **Very anxious** |
| How much tenderness to touch have you felt? | **No tenderness** | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | **Very tender** |
| How much has balance and coordination been a problem *(e.g. falling)?* | **No imbalance** | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | **Severe imbalance** |
| How much environmental sensitivity have you had *(e.g. noises, lights, odors, cold)*? | **No sensitivity** | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | **Extreme sensitivity** |

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

**SIQR TOTAL** ***(for internal use only)*** ☐