

MUSCULOSKELETAL CENTER
Business Office
Phone: 817-247-1130
Fax: 817-292-7930

Locations:
Fort Worth
Dallas
Colleyville

FIBROMYALGIA QUESTIONNAIRE

Name _____ Date _____ Date of Birth _____

When did you receive your current diagnosis? _____

Please describe your main problem: _____

When did it begin? _____; was there a specific event that

seemed to trigger the onset of your symptoms? Yes No If yes, what was the event _____

_____; If no, describe how your symptoms began and progressed

_____; is it getting: better, worse, or staying the same (circle one)

Please describe activities or things that you cannot do because of your problem _____

SOCIAL HISTORY:

Marital Status _____ Ages of children living at home? _____

Education level _____

What are your hobbies? _____

Attitude Towards Problem

- No problem
- Minor inconvenience
- Slight problem
- Moderate problem
- Major problem

Confidence in Controlling Your Problem

- Complete confidence
- Moderate confidence
- Little confidence
- No confidence

DIET:

Are you currently on a special diet? Yes No If yes, please describe _____

Daily Fluid Intake: (enter number of 8 oz cups/glasses of fluid taken daily)

- Water _____
- Caffeinated drinks (coffee, tea, colas, chocolate) _____
- Decaffeinated drinks (coffee, tea, colas) _____
- Alcohol _____
- Juices _____
- Other _____

FUNCTIONAL LIMITATIONS: (check yes or no)

Do you have difficulty:

- Getting on/off the toilet? Yes No
- Getting clothes on/off? Yes No
- With toilet hygiene? Yes No
- Getting out of bed? Yes No

List strategies you use to control your symptoms: _____

What goals do you hope to achieve in this program? _____