



**McGill Short Form Questionnaire**

Name: \_\_\_\_\_

Age: 43

ID Number: 000000000029

Reviewed by: \_\_\_\_\_

Date Tested: 1/10/2007 7:12:00 PM

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|      |   |          |
|------|---|----------|
|      | <b>Sensory Pain Rating Index (S-PRI)</b>                  | <b>0</b> |
|      | <b>Affective Pain Rating Index (A-PRI)</b>                | <b>0</b> |
|      | <b>Total Pain Rating Index (T-PRI)</b>                    | <b>0</b> |
| S1.  | Throbbing   | None     |
| S2.  | Shooting  | None     |
| S3.  | Stabbing  | None     |
| S4.  | Sharp   | None     |
| S5.  | Cramping  | None     |
| S6.  | Gnawing   | None     |
| S7.  | Hot-Burning   | None     |
| S8.  | Aching  | None     |
| S9.  | Heavy   | None     |
| S10. | Tender  | None     |
| S11. | Splitting   | None     |
| S12. | Tiring-Exhausting   | None     |
| S13. | Sickening   | None     |
| S14. | Fearful   | None     |
| S15. | Punishing-Cruel   | None     |
| S16. | Mark your average pain on the line.                       | 1        |
| S17. | Please indicate which statement best describes your pain. | Mild     |

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## RAND 36 Intake Report

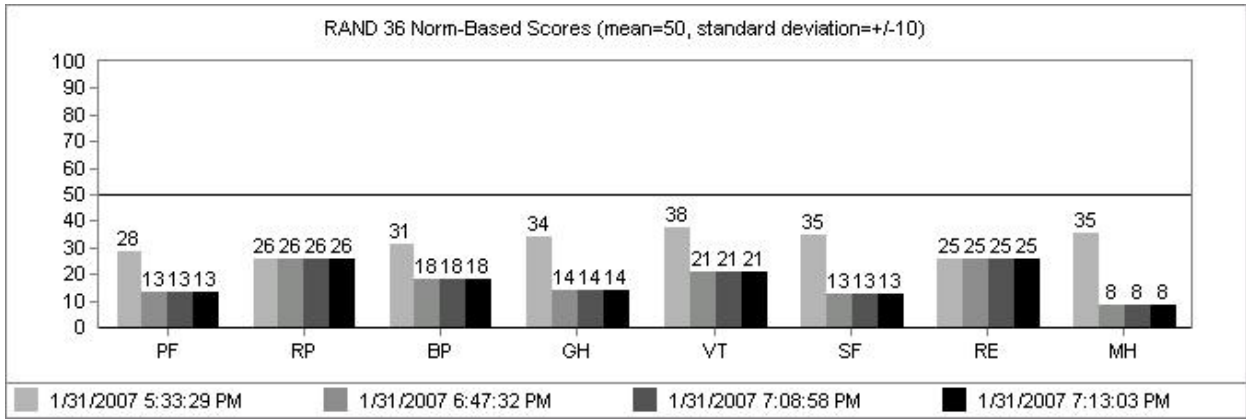
Name: \_\_\_\_\_

ID Number: 000000000029

Age: 43

Date Tested: 1/10/2007 7:13:03 PM

Gender: Female



**RAND 36 Item Responses:**

Health in general  
 Health compare to year ago  
 Vigorous activities  
 Moderate activities  
 Lifting or carrying groceries  
 Climbing several flights  
 Climbing one flight of stairs  
 Bending, kneeling, or stooping  
 Walking more than a mile  
 Walking several blocks  
 Walking one block  
 Bathing or dressing yourself  
 PH - Cut down the amount of time  
 PH - Accomplished less would like  
 PH - Were limited in the kind of work  
 PH - Had difficulty performing  
 EP - Cut down the amount of time  
 EP - Accomplished less would like

EP - Did activities less carefully  
 Physical or emotional interfered  
 Bodily pain past 4 weeks  
 Pain interfere with normal work  
 Did you feel full of pep  
 Have you been very nervous  
 Down in the dumps  
 Have you felt calm and peaceful  
 Did you have a lot of energy  
 Have you felt downhearted/depressed  
 Did you feel worn out  
 Have you been happy  
 Did you feel tired  
 Physical/emotional interfere social  
 Get sick a little easier than others  
 I am as healthy as anybody I know  
 I expect my health to get worse  
 My health is excellent

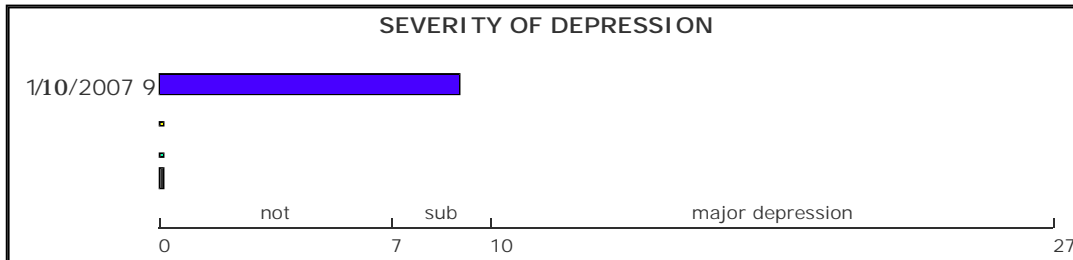


## Patient Health Questionnaire - PHQ-9



**Name:** \_\_\_\_\_ **Gender:** Female  
**ID:** 000000000029 **Age:** 43  
**Date:** 1/10/2007 7:13:00 PM

PHQ-9 Score = 0



| ITEM   | RESPONSE   |
|--|------------|
| 1. Feeling down, depressed, or hopeless.   | Not at all |
| 2. Little interest or pleasure in doing things.  | Not at all |
| 3. Trouble falling or staying asleep, or sleeping too much   | Not at all |
| 4. Feeling tired or having little energy.  | Not at all |
| 5. Poor appetite or overeating.  | Not at all |
| 6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down.  | Not at all |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television.  | Not at all |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual. | Not at all |
| 9. Thoughts that you would be better off dead or hurting yourself in some way.   | Not at all |

#### PHQ-9 Scoring

The PHQ-9 is scored by summing the ratings for the 9 items. Each item is rated on a 4-point scale ranging from 0 to 3. The maximum total score is 27.

| Score      | Interpretation           |
|------------|--------------------------|
| 0 - 6      | not clinically depressed |
| 7 - 9      | sub-threshold depression |
| 10 or more | major depression         |

## Zung Anxiety Report



Name: \_\_\_\_\_

Gender: Female

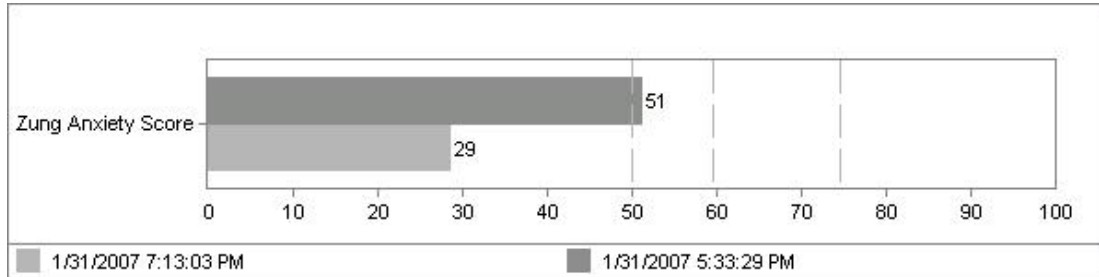
ID Number: 000000000029

Age: 43

Date Tested: 1/10/2007 7:13:03 PM

Reviewed by: \_\_\_\_\_

**Zung Anxiety Result:** Severity = 29, Within Normal Limits



|  |                                   |
|--|-----------------------------------|
| 1. I feel more nervous and anxious than usual                      | None OR Little of the Time        |
| 2. I feel afraid for no reason at all                              | None OR Little of the Time        |
| 3. I get upset easily or feel panicky                              | None OR Little of the Time        |
| 4. I feel like I'm falling apart and going to pieces               | None OR Little of the Time        |
| 5. I feel that everything is all right and nothing bad will happen | Most OR All of The Time           |
| 6. My arms and legs shake and tremble                              | None OR Little of the Time        |
| 7. I am bothered by headaches, neck, and back pains                | None OR Little of the Time        |
| 8. I feel weak and get tired easily                                | None OR Little of the Time        |
| 9. I feel calm and can sit still easily                            | Most OR All of The Time           |
| 10. I can feel my heart beating fast                               | None OR Little of the Time        |
| 11. I am bothered by dizzy spells                                  | None OR Little of the Time        |
| 12. I have fainting spells or feel faint                           | None OR Little of the Time        |
| 13. I can breathe in and out easily                                | Most OR All of The Time           |
| 14. I get feelings of numbness and tingling in my fingers, toes    | None OR Little of the Time        |
| 15. I am bothered by stomach aches or indigestion                  | None OR Little of the Time        |
| 16. I have to empty my bladder often                               | None OR Little of the Time        |
| 17. My hands are usually dry and warm                              | <b>None OR Little of the Time</b> |
| 18. My face gets hot and blushes                                   | None OR Little of the Time        |
| 19. I fall asleep easily and get a good night's rest               | Most OR All of The Time           |
| 20. I have nightmares  | None OR Little of the Time        |

Note: Item responses are from the most recent test administration.