



Comprehensive Care
Rheumatology • Naturopathy • Acupuncture • Yoga Therapy

Fibromyalgia Impact Questionnaire (FIQ)

Name: _____

Date: _____

Directions for questions 1 – 11: Please circle the number that best describes how you did overall for the past week. If you don't normally do something that is asked, cross item out.

Were you able to:	Always	Most	Occasionally	Never
1. Do shopping?	0	1	2	3
2. Do laundry with a washer/dryer?	0	1	2	3
3. Prepare meals?	0	1	2	3
4. Wash dishes/cooking utensils by hand?	0	1	2	3
5. Vacuum a rug?	0	1	2	3
6. Make beds?	0	1	2	3
7. Walk several blocks?	0	1	2	3
8. Visit friends or relatives?	0	1	2	3
9. Do yard work?	0	1	2	3
10. Drive a car?	0	1	2	3
11. Climb stairs?	0	1	2	3

12. Of the 7 days in the past week, how many days did you feel good?
 0 1 2 3 4 5 6 7

13. How many days last week did you miss work/housework or school because of fibromyalgia?
 0 1 2 3 4 5 6 7

Directions for questions 14 – 20: Place a mark that indicates how you felt overall for the past week.

14. When you worked, how much did pain or other symptoms of your fibromyalgia interfere with your ability to do your work, including housework?

No Problem with Work ● _ | _ | _ | _ | _ | _ | _ | _ | _ | _ ● Great Difficulty

15. How bad has your pain been?

No Pain ● _ | _ | _ | _ | _ | _ | _ | _ | _ | _ ● Very Severe Pain

16. How tired have you been?

No Tiredness ● _ | _ | _ | _ | _ | _ | _ | _ | _ | _ ● Very Tired

17. How have you felt when you get up in the morning?

Awoke Well Rested ● _ | _ | _ | _ | _ | _ | _ | _ | _ | _ ● Awoke Very Tired

18. How bad has your stiffness been?

No Stiffness ● _ | _ | _ | _ | _ | _ | _ | _ | _ | _ ● Very Stiff

19. How nervous or anxious have you felt?

Not Anxious ● _ | _ | _ | _ | _ | _ | _ | _ | _ | _ ● Very Anxious

20. How depressed or blue have you felt?

Not Depressed ● _ | _ | _ | _ | _ | _ | _ | _ | _ | _ ● Very Depressed