Geriatric Pain Measure – GPM

Name _____ **Date**_____

Please answer each question	Answer	Score
1. Do you or would you have pain with vigorous activities such as running, lifting heavy objects or participating in strenuous sports?	No Yes	___
2. Do you or would you have pain with moderate activities such as moving a heavy table, pushing a vacuum cleaner, bowling or playing golf?	No Yes	___
3. Do you or would you have pain with lifting or carrying groceries?	No Yes	___
4. Do you or would you have pain with climbing more than one flight of stairs?	No Yes	___
5. Do you or would you have pain with climbing only a few steps?	No Yes	___
6. Do you or would you have pain walking more than one block?	No Yes	___
7. Do you or would you have pain walking one block or less?	No Yes	___
8. Do you have pain with bathing or dressing?	No Yes	___
9. Have you cut down the amount of time you spend on work or doing activities because of pain?	No Yes	___
10. Have you been accomplishing less than you would like because of pain?	No Yes	___
11. Have you limited the kind of work or other activities you do because of pain?	No Yes	___
12. Does the work or activities you do require extra effort because of pain?	No Yes	___
13. Do you have trouble sleeping because of pain?	No Yes	___
14. Does pain prevent you from attending religious activities?	No Yes	___
15. Does pain prevent you from enjoying any other social or recreational activities (other than religious services)?	No Yes	___
16. Does or would pain prevent you from traveling or using standard transportation?	No Yes	___
17. Does pain make you feel fatigued or tired?	No Yes	___
18. Do you have to rely on family members or friends for help because of pain?	No Yes	___
19. On a scale of zero to ten, with zero meaning no pain, with ten being the worst pain you can imagine, how severe is your pain today? ____ 0 1 2 3 4 5 6 7 8 9 10 10	No Yes	___
20. In the last seven days, on a scale of zero to ten, with zero meaning no pain, with ten being the worst pain you can imagine, how severe has your pain been on average? ____ 0 1 2 3 4 5 6 7 8 9 10 10	No Yes	___
21. Do you have pain that never completely goes away?	No Yes	___
22. Do you have pain every day?	No Yes	___
23. Do you have pain several times a week?	No Yes	___
24. Over the last seven days, has pain caused you to feel sad or depressed?	No Yes	___

SCORING: Give one point for each yes response and add the numerical responses

TOTAL SCORE (0-42) _____ **Adjusted Score (Total Score X 2.38) (0-100) _____**

<30 Mild Pain *30-69 Moderate Pain* *>70 Severe Pain*