

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Musculoskeletal Outcome Measures (MOM-40)

For the following questions, circle the number that best fits how you feel about your pain problem.

1. Please rate your pain on the scale below from 0 to 10. Please circle one number that best fits your **average** level of pain **in the last week**. For example, very mild pain = 1, severe pain = 8.

NO PAIN

WORST PAIN  
IMAGINABLE

0	1	2	3	4	5	6	7	8	9	10
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2. During **the past week** to what extent have you:

	Not at All	Mildly	Moderately	Very Much	Totally, Constantly
a) Needed to lie down during the day	0	1	2	3	4
b) Felt downhearted and sad	0	1	2	3	4
c) Felt nervous and uptight	0	1	2	3	4
d) Felt tired and lacking in energy	0	1	2	3	4
e) Had trouble sleeping	0	1	2	3	4
f) Had headaches	0	1	2	3	4
g) Felt dizziness	0	1	2	3	4

For the following questions, check a box that best matches your answer.

3. How confident are you that you can do most things (live a normal lifestyle despite your pain)?  
 Not at all    A little    Moderately    Quite a lot    Extremely    Completely
4. Over the course of treatment for your pain, how satisfied were you with your overall medical care?  
 Very Dissatisfied    Somewhat Dissatisfied    Neither satisfied nor Dissatisfied    Somewhat Satisfied    Very Satisfied
5. If you had to spend the rest of your life with the symptoms you have right now, how would you feel about it?  
 Very Dissatisfied    Somewhat Dissatisfied    Neither satisfied nor Dissatisfied    Somewhat Satisfied    Very Satisfied
6. During the past four weeks, how many times did you attend a doctor or other health care provider in relation to your pains? Mark the total number of visits to all medical providers:  
 0    1 time    2-3 times    4-5 times    6-7 times    8 or more times
7. Write down the types of health care providers you have seen below (e.g., doctor, chiropractor, massage therapist, etc.): \_\_\_\_\_
8. Medications: During the past week, on average, how many tablets for pain have you taken per day?  
 None    Occasional    1-2 per day    3-5 per day    6-8 per day    more than 8 per day

*Please turn over now and complete the second page*

9. **For your doctor to answer:** What type of medication is taken?

- 0    Simple Analgesics    Compound Analgesics    Compound Analgesics & Psychotropics    Strong Opiates

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## **MOM Disability Scale**

**Circle the best option for each question**

10. During the past week, how difficult was it (or would it have been) for you to do the following activities:

	No trouble	A bit difficult	Moderately difficult	Very difficult	Cannot do at all	
a) Your normal work (including both work outside the home and housework)	0	1	2	3	4	
b) Your normal social activities	0	1	2	3	4	
c) Your usual sport and recreation	0	1	2	3	4	
d) Getting dressed, bathing and personal hygiene	0	1	2	3	4	
e) Usual sexual activity	0	1	2	3	4	
f) Traveling in a car	0	1	2	3	4	
g) Traveling by public transport	0	1	2	3	4	
h) Walking 100 meters	0	1	2	3	4	
i) Walking on the flat for more than one kilometer	0	1	2	3	4	
j) Walking on uneven ground	0	1	2	3	4	
k) Walking up and down stairs	0	1	2	3	4	
l) Kneeling and squatting	0	1	2	3	4	
m) Rising from sitting	0	1	2	3	4	
n) Running	0	1	2	3	4	
o) Bending forwards or stooping	0	1	2	3	4	
p) Lifting and carrying (10 kg. or 22 lbs.)	0	1	2	3	4	
q) Sitting at a desk	0	1	2	3	4	
r) Looking up and down	0	1	2	3	4	
s) Turning your head to look over your shoulder	0	1	2	3	4	
t) Reaching overhead to a high shelf	0	1	2	3	4	
u) Writing at a desk or typing at a keyboard	0	1	2	3	4	
v) Lifting or carrying groceries	0	1	2	3	4	
w) Reaching up behind your back	0	1	2	3	4	
x) Throwing a ball	0	1	2	3	4	
y) Opening tight jars or bottle tops	0	1	2	3	4	
<b>For Office Use Only</b>	<b>Disability Score</b>		<b>/100</b>	<b>Pain</b>		<b>/100</b>