

Visual Function Index

Name _____

We must understand how much your pain has affected your ability to manage **everyday activities**.
Please, circle one choice which most closely describes your problem right now.

Date _____

1. Pain Intensity

0	1	2	3	4	5
No pain	Mild pain	Moderate pain	Severe pain	Very severe pain	Worst possible pain

6. Recreation

0	1	2	3	4	5
Can do all activities	Can do most activities	Can do many activities	Can do some activities	Can do a few activities	Can do no activities

2. Sleeping

0	1	2	3	4	5
Perfect sleep	Slightly disturbed sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

7. Change of Pain

0	1	2	3	4	5
Pain improving quickly	Pain improving gradually	Pain improving very slowly	No change gradually	Pain gradually worsening	Pain worsening quickly

3. Personal Care

0	1	2	3	4	5
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need a little assistance	Moderate pain; need some assistance	Severe pain; need 100% assistance

8. Lifting

0	1	2	3	4	5
No pain with heavy weight	Slight pain with heavy weight	Moderate pain with heavy weight	Slight pain with medium weight	Moderate pain with medium weight	Severe pain with light weight

4. Driving

0	1	2	3	4	5
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips	Severe Pain; cannot drive

9. Walking

0	1	2	3	4	5
No Pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain after 100 yards	Severe pain all walking

5. Work

0	1	2	3	4	5
Can do usual work plus unlimited extra work	Can do usual work; no extra	Can do 75% usual	Can do 50% usual	Can do 25% usual	Cannot work

10. Standing

0	1	2	3	4	5
No pain after several hours	Slight pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain after 10 mins	Severe pain with any standing