



FIBROMYALGIA SCREENING
QUESTIONNAIRE (FSQ)

MR#: _____
Name: _____
Date: _____
MD: _____

1. Please indicate below if you've had pain or tenderness during the past **7 days** in each of the areas listed below.

Please mark X in ☐ below if you've had pain or tenderness. Be sure to mark both your right and left sides separately.

FRONT		BACK	
Jaw ☐	Jaw ☐		Neck ☐
Shoulder ☐	Shoulder ☐	Upper Back ☐	Upper Arm ☐
Chest or Breast ☐		Upper Arm ☐	Upper Arm ☐
Abdomen ☐		Lower Back ☐	
Lower Arm ☐	Lower Arm ☐	Hip or Buttocks ☐	Hip or Buttocks ☐
Upper Leg ☐	Upper Leg ☐	Lower Leg ☐	Lower Leg ☐
RIGHT	LEFT	LEFT	RIGHT

2. Using the scale below, indicate for each item the level of severity over the **past week** by checking the appropriate box.

	No Problem	Slight or Mild	Moderate	Severe
a. Fatigue	☐	☐	☐	☐
b. Trouble thinking or remembering	☐	☐	☐	☐
c. Waking up tired (unrefreshed)	☐	☐	☐	☐

3. During the **past 6 months** have you had any of the following symptoms?

a. Pain or cramps in lower abdomen	☐ Yes	☐ No
b. Depression	☐ Yes	☐ No
c. Headache	☐ Yes	☐ No

4. Overall, were the symptoms listed in questions 1–3 above generally present for **at least 3 months**?

☐ Yes ☐ No

5. Do you have a disorder that would otherwise explain the pain?

☐ Yes ☐ No