

Health Assessment Questionnaire

Name: _____ DOB: _____ Date: _____

We are interested in learning how your illness affects your ability to function in daily life. Place an "X" in the box which best describes your usual abilities *OVER THE PAST WEEK*:

| Are you able to: | Without Any Difficulty (0) | With Some Difficulty (1) | With Much Difficulty (2) | Unable to Do (3) |
|--|----------------------------------|--------------------------------|--------------------------------|--------------------------|
| Dress yourself, including shoelaces and buttons? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Shampoo your hair? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Get in and out of bed? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stand up from a straight chair? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lift a full cup or glass to your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cut your meat? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Open a new milk carton? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walk out door on flat ground? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb up five steps? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

HOW MUCH PAIN have you had because of your illness in the past week? Place an "X" on the line below that best describes your pain on a scale of 0-100.

NO PAIN 0 100 SEVERE PAIN

| | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| Wash and dry your body? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Get on and off the toilet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Take a tub bath? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bend down to pick up clothing from the floor? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach and get down a 5 pound object (such as a bag of sugar) from just above your head? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Turn faucets on and off? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Open jars that have been previously opened? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Open car doors? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Get in and out of a car? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Run errands and shop? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do chores such as vacuuming or yard work? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

PLEASE CONTINUE TO THE NEXT PAGE

Below is a list of statements that other people with your illness have said are important. **By circling one (1) number per line, please indicated how true each statement has been for you during the past 7 days.**

| | Not at all | A little bit | Some-what | Quite a bit | Very much |
|--|------------|--------------|-----------|-------------|-----------|
| I feel fatigued----- | 0 | 1 | 2 | 3 | 4 |
| I feel weak all over ----- | 0 | 1 | 2 | 3 | 4 |
| I feel listless ("washed out")----- | 0 | 1 | 2 | 3 | 4 |
| I feel tired----- | 0 | 1 | 2 | 3 | 4 |
| I have trouble starting things because I am tired ----- | 0 | 1 | 2 | 3 | 4 |
| I have trouble finishing things because I am tired ----- | 0 | 1 | 2 | 3 | 4 |
| I have energy----- | 0 | 1 | 2 | 3 | 4 |
| I am able to do my usual activities ----- | 0 | 1 | 2 | 3 | 4 |
| I need to sleep during the day----- | 0 | 1 | 2 | 3 | 4 |
| I am too tired to eat ----- | 0 | 1 | 2 | 3 | 4 |
| I need help doing my usual activities ----- | 0 | 1 | 2 | 3 | 4 |
| I am frustrated by being too tired to do the things I want to do ----- | 0 | 1 | 2 | 3 | 4 |
| I have to limit my social activity because I am tired ----- | 0 | 1 | 2 | 3 | 4 |

Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

| | Not at all | Several days | More than half the days | Nearly every day |
|---|------------|--------------|-------------------------|------------------|
| | 0 | 1 | 2 | 3 |
| a. Little interest or pleasure in doing things | | | | |
| b. Feeling down, depressed, or hopeless | | | | |
| c. Trouble falling asleep, staying asleep, or sleeping too much. | | | | |
| d. Feeling tired or having little energy. | | | | |
| e. Poor appetite or overeating. | | | | |
| f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down. | | | | |
| g. Trouble concentrating on things such as reading the newspaper or watching television. | | | | |
| i. Thinking that you would be better off dead or that you want to hurt yourself in some way | | | | |
| Totals: | | | | |

PLEASE CONTINUE WITH THE NEXT PAGE TO COMPLETE THE QUESTIONNAIRE

CONSIDERING ALL THE WAYS THAT YOUR ILLNESS AFFECTS YOU, rate how you are doing on the following scale. Place an "X" on the line below that best describes how you are doing on a scale of 0-100.



STOP - NO MARKS BELOW THIS POINT

